



# Community Health Advisors/ Workers

Selected Annotations and Programs in the United States

Volume III

*June 1998*



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Centers for Disease Control and Prevention  
National Center for Chronic Disease Prevention and Health Promotion  
Division of Adult and Community Health

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**Community Health Advisors/Workers: Volume III**  
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## About Community Health Advisors

“If the problems are in the community...the solutions are in the community.”

*Gilbert Friedell, MD  
Director of Cancer Control  
Kentucky Cancer Program  
Lucille P. Markey Cancer Center  
Lexington, Kentucky*

“When asked why I am so sold on working with community health advisors in community-driven health promotion, I answer with four main points:

IT’S FUN,

IT WORKS,

IT LASTS,

IT’S THE RIGHT THING TO DO!

But even I must admit that CHA programs can be hard to explain, evaluate, and fund, and they take time to implement. Nevertheless, I firmly believe that CHAs and programs like CHAN are essential components of the solution to this nation’s health problems.”

*Agnes W. Hinton, Ph.D., RD, LN  
Director  
Community Health Advisor Network  
University of Southern Mississippi  
Hattiesburg, Mississippi*

“Many of the most intractable health problems plaguing communities today—infant mortality among African Americans, asthma among poor children, violence among inner-city youth—are the result of environmental, social, and economic conditions. As health care workers who combine an intimate understanding of communities with knowledge about health issues and the health care system, Community Health Advisors are uniquely suited to address these underlying determinants of health and create healthier communities.”

*Noel Wiggins, MSPH  
Health Services Specialist  
Multnomah County Health Department  
Portland, Oregon*

“It is important that people entering the field of Community Health Work are aware of the rich cultural history. The modern “Community Health Advisor” is the grandchild of the historical “Granny Midwife”, “Curandera”, “Mama Lua”, “Partiera”, or “Sage-Femme”. These community healers were much more loosely connected to the formal health care system, but depended upon greatly. They have been the medical system’s link to disenfranchised and difficult to reach communities wherever they were, now and then.”

*Aminyah Muhammad  
Life Skills Educator  
For Love of Children  
Washington, DC*

“From the late 1960's to 1998 Community Health Workers have come full circle:

In the early years the scope of work was unstructured, the role was not clearly defined, and agencies were generally apathetic. But in time we proved our worth through commitment and dedication to the community as members of the health care services team. By the end of the 1980's many community health workers were written out of funded programs while those who remained were stripped of responsibilities and given limited duties.

Now, there is renewed interest in the community health worker field and the current health care environment presents a valuable opportunity to capitalize on the strengths and contributions of community health workers. This is a very exciting time for us and after over 27 years of experience as a community health worker, I am very proud to be a part of this history. Though much work has been accomplished over the last three years, there is still much to be done. We must seize this moment.”

*Yvonne Lacy  
Community Health Worker Specialist  
City of Berkeley  
Health and Human Services Department  
Berkeley, California*

## Preface

**T**he mission of the Centers for Disease Control and Prevention (CDC) is to promote health and quality of life by preventing and controlling disease, injury, and disability. As the nation's prevention agency, CDC accomplishes its mission by working with partners throughout the nation and the world to monitor health, detect and investigate health problems, conduct research to enhance prevention, develop and advocate sound public health policies, implement prevention strategies, promote healthy behaviors, foster safe and healthful environments, and provide leadership and training.

In the United States, community health advisors\* foster these goals by conducting community-level activities and interventions that promote health and prevent diseases. These advisors are trusted, respected members of the community who serve as a bridge between their peers and health professionals. Their informal, but direct, involvement enhances the delivery of health-related services and information to diverse populations, including minority, rural, and underserved populations. They provide a vital service by establishing and maintaining relationships with health care professionals and laypersons in the community. As health advocates, community health advisors promote and encourage positive, healthful behaviors among their peers.

In recent years, community health advisors have experienced a resurgence in their role in the community. We have added the term Community Health Worker to the title of this document because increasing numbers of community members who serve their communities and the changing health care system, including managed care organizations, are being called community health workers. They are currently involved in a variety of CDC-funded projects in such areas as HIV/AIDS, breast and cervical cancer, cardiovascular disease, diabetes, maternal and child health, nutrition, immunizations, and tuberculosis.

To emphasize the important work being done by indigenous health workers at the community and neighborhood levels, we have prepared an extensive bibliography by searching bibliographic databases and by contacting organizations, programs, and individuals engaged in community-based activities and interventions. During our search, we may have overlooked some excellent source materials. If you find that your program or article is not listed, we invite you to furnish information about your project by filling out the program data sheet located at the back of Volume III. We will include your program or research when we update the bibliography.



\*The term community health advisor/worker denotes trusted and respected community members who provide informal community-based health-related services and who establish vital links between health care professionals in local public health departments and persons in the community. In the following list, we have tried to include some of the different terms that may be used to identify these lay-health community members:

Community health advocate	Lay community health worker
Community health aide	Lay health worker
Community health representative	Lay volunteer
Community helper	Natural caregiver
Family health promoter	Natural helper
Health facilitator	Outreach worker
Health liaison	Paraprofessional
Health promoter	Peer counselor
Health visitor	Peer health advisor
Home visitor	Peer health educator
Indigenous health aide	Promotora
Indigenous paraprofessional	Resource mother
Informal helper	Volunteer health educator

On the following pages you will find two manuscripts. The first presents the results of the analyses of the information provided by the 140 CHA/CHW programs in Volume II; it provides insights into how CHA's are recruited, trained, managed, and retained by agencies, and it makes management recommendations for improving these tasks and the agency working environment. The second paper reveals some differences between rural and urban CHA programs and makes further management recommendations.

# Article 1

## Community Health Advisor Use: Insights from a National Survey

Katherine Wilson, MPH, CHES; J. Nell Brownstein, Ph.D.; Curtis Blanton, MS

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The authors acknowledge assistance provided by Susan Ackermann, Ph.D., Barbara Dougherty, and Fonda Martin.

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## Community Health Advisor Use: Insights from a National Survey - Abstract

This article presents the results of a national survey of 140 Community Health Advisor (CHA) programs in the U.S., contained in Volume II of this series. The results showed that: CHA programs reach all age, racial, and ethnic groups in both rural and urban areas; services are delivered at the community level; and CHA's primary role is to educate and promote health. Providing training, compensation, and a positive work environment; being respectful of the individual; and having a clearly defined scope of duties were the most effective means of retaining CHAs. We recommend that agencies consider developing a long-term training plan and a compensation program, reviewing their agency's work environment, and planning a recruitment strategy.

**Key Words:** Community Health Advisors, health promotion, training, strategies

## Introduction

A Community Health Advisor (CHA) is a natural helper—a trusted, respected, and well-known indigenous member of the community to whom others naturally turn for support, health advice, resources, and referrals<sup>1,2</sup>. He or she is a bridge between community members and local health and human services professionals<sup>2,3</sup>. The informal, but direct, involvement of CHAs enhances the delivery of health-related information and services to diverse groups, including minority, rural, and underserved populations<sup>4,5</sup>. Using CHAs can be an effective, low-cost way to increase community members' access to health care; improve health status; change negative health-related behavior or reinforce positive behavior; change health-related attitudes, values, beliefs; place relevant information into an appropriate cultural context; and increase health knowledge<sup>5-8</sup>. CHA programs have improved communication between community members and health professionals; bridged the cultural gap; improved the delivery of health services to vulnerable populations such as low-income, ethnic, and rural and neighborhood groups; and assisted community residents in resolving their own needs and problems (individual and



community empowerment)<sup>1,5,7,9-12</sup>. Many different names identify CHAs. Some commonly used names include community health workers, community health aides, promotoras, consejeras, natural helpers, lay health workers, outreach workers, peer counselors, home visitors, community health representatives, and resource mothers. The National Community Health Advisor Study identified 66 distinct (although often similar) titles for CHAs<sup>13</sup>.

Although CHAs have been used for a long time in other countries, the use of CHAs to assist with public health programs began in the United States in the 1950s and 1960s and since then has gone in and out of fashion<sup>9</sup>. Within the past five years, there has been a resurgent interest in, and use of, CHAs because of increased health care costs, limited health care access, and the growth of minority and underserved populations. Many CHA programs serve the traditional audiences of the state and local health departments. Using CHAs can help these agencies reach their audiences, but only if agencies effectively integrate CHAs into their programs.

This analysis presents to agencies that use, or are considering the use of, CHA programs, program managers' insights into the most effective strategies for recruiting, managing, and retaining CHAs.

## **Methods**

The National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, conducted a national survey of Community Health Advisor (CHA) programs to establish a coordinated, central source of information on them. A secondary analysis of the survey data provides insights into how CHAs are recruited, trained, managed, and retained by agencies.

### *Sample*

The CHA program survey was a nonprobability, convenience sample of CHA programs in the United States. With a nonprobability sample, inferences can be made only about the respondents to the survey and not about all U.S. CHA programs. Nevertheless, because of the number and variety of respondents, the authors believe that the respondents gave meaningful insights into CHA programs. Surveys were sent to recipients of Federal funding for breast and cervical cancer screening and diabetes education and screening, state directors of health education and health promotion, state directors of chronic disease programs, state directors of education, rural health directors, participants of the Arizona "Peer Health Education" conference, Resource Mothers program directors and staff, and attendees of CHA sessions at the 1993 American Public Health Association Annual Meeting. Also, respondents were solicited through the National Center for Chronic Disease Prevention and Health Promotion's "Chronic Disease Notes and Reports" and through the newsletter of the Public Health Education and Health Promotion Section of the American Public Health Association. All surveys were completed by program managers, not CHAs.

### *Instrument*

The CHA program survey (found in volume II) has 33 items divided into three sections: a) identifying information; b) program setting, which includes the type of agency delivering programs, health topics

covered, site of program delivery, target populations served, hours worked, compensation, training, and funding sources; and c) program information, including the number of CHAs, number of clients served, percentage of CHAs who are members of the target group, titles and roles for CHAs. All but four questions use a checklist format where multiple responses were possible. The remaining four questions, which deal with key issues of recruitment and retention, were written in an open-ended format to identify responses that may be used to develop a future survey. Respondents also were invited to attach descriptive program materials and evaluation plans.

We developed the questions with guidance from experienced CHA practitioners. The draft survey was field tested with academics, CHAs and program managers who participated in the “Peer Health Education: Mobilizing Resources for Practice, Policy, and Research” conference held February 7-8, 1993, in Tucson, AZ. Since the primary purpose of the survey was to collect program descriptions for an electronic database, we did not think that including the responses to the field test would bias the study outcome.

### *Data analysis*

All responses were entered into Epi Info I, version 5<sup>14</sup>. Frequencies and percentages were tabulated using SAS software. A response rate is impossible to calculate, since the number of CHA programs in the United States is unknown and no record of secondary distribution of the survey exists.

We used the constant comparative method<sup>15</sup> to analyze the qualitative data from the four open-ended questions. This method uses open coding to identify salient themes, which are grouped and defined as categories. Once defined, we used categories to condense and analyze survey data. The themes for retaining CHAs were developed with assistance from a human resources expert, since many aspects of retaining CHAs are similar to those of retaining other workers. To test inter-rater reliability, a second person coded the same responses by using the response theme list, which is shown in Table 1.

**Table 1. Response themes for recruiting and retaining CHAs**

<b><i>Recruiting</i></b>	<b><i>Retaining</i></b>
Advertising	Training
Word-of-mouth referrals	Compensation, such as salary, incentives, benefits, or stipends
Referrals from community and social service groups	Working environment
Referrals from current CHAs	Standard operating procedures (agency)
Networking with people in other CHA programs	Scope of work (for CHA)

Three of these themes are given specific definitions for this analysis. Standard operating procedures describes operation norms for the agency or the set of guidelines under which an agency, organization, or other group conducts business to achieve objectives. Scope of work addresses the individual tasks, performances, expectations, and responsibilities related to a position, not to a person. Working environment includes the contact with and support of other employees, relationships between employees and supervisors, communication, recognition and appreciation, respect, and cultural sensitivity.



## Results

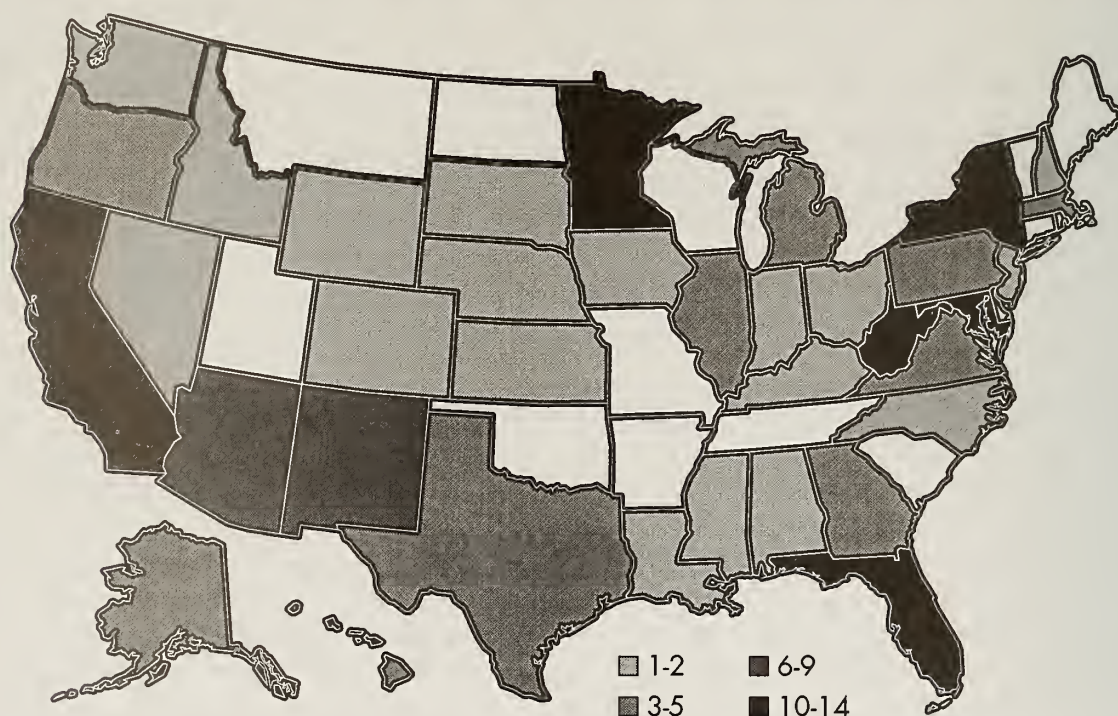
### *Profile of programs*

Program managers from 36 states and the District of Columbia completed 140 surveys. The largest number of respondents was from California (14), Florida (13), and Minnesota (12) (Figure 1). Fifty-six percent of these programs were funded exclusively by public monies, 14 percent received private funding exclusively, and the remaining 30 percent drew support from various combinations of public and private funds. (Table 2).

**Table 2. Funding sources for CHA programs**

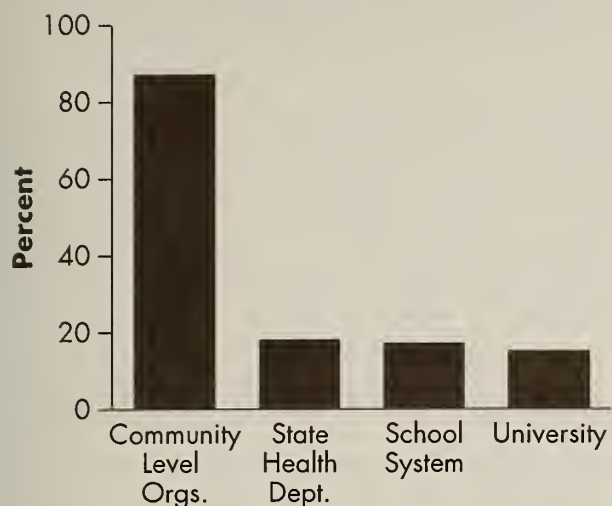
State	56.9%
Federal	46.9%
Private foundations	26.9%
Local	21.5%
Nonprofit	20.0%
Voluntary agencies	3.8%

**Figure 1. Community Health Advisor survey respondents per state**



Most (75%) of the organizations delivering CHA programs described themselves as community-based organizations, and included local health departments, local hospitals, and clinics. Only 16% of the programs were delivered by state health departments (Figure 2). In 95% of the programs, CHAs were members of the target community. In most cases, CHAs were trained by local health educators and nurses. Most CHA interventions were conducted in homes (76%) and in other community sites such as schools, worksites, religious institutions, public health clinics, and medical clinics. Some programs

**Figure 2. Organizations that deliver CHA Programs**



were conducted in community and senior citizen centers, soup kitchens, and food pantries.

Although the great majority (94%) of programs reached adult women, a large proportion (73%) of programs reported having males as their clients. Most programs served the following racial and ethnic groups: whites (served by 69% of programs), blacks (62%), and Hispanics (57%). A much smaller percentage of programs reported serving Asians/Pacific Islanders (13%) and Alaska natives (12%).

Over half of the programs that responded included counseling on pregnancy (63%), nutrition (60%), family planning (58%), substance abuse (57%), and HIV/AIDS (51%). Violence was listed as a topic in 44% of the programs. Chronic diseases were also addressed in a substantial

percentage of programs: 45% of programs addressed smoking, 31% addressed cancer, and 31% addressed physical activity. Newer areas addressed by CHA programs included mental health and health issues of the elderly (both areas were addressed in 10% of the programs).

We used Eng's classification of CHA roles<sup>8</sup> to categorize the different functions that CHAs served. Ninety-three percent provided health education and health promotion, 79% conducted outreach, 72% served as patient and client advocates, 70% offered social support, and 60% conducted community advocacy. CHAs were less frequently reported to function in assessing risk (43%), providing transportation (39%), and providing treatment (23%).

#### *CHA recruitment profile*

Respondents listed the three most effective methods of recruiting CHAs as advertising, word-of-mouth referrals, and referrals from community groups. Forty-nine percent of respondents said they advertised for CHAs in community presentations, local radio and newspapers, religious bulletins, and public announcements. Forty-five percent used word-of-mouth recruitment. Thirty-four percent solicited referrals from community and religious leaders, social workers, and health professionals. Less frequently used methods were obtaining referrals from current CHAs within their program (31%) and networking with other CHA programs (24%).

#### *CHA retention profile*

The respondents reported that the best methods of retaining CHAs were to offer training (45%), and compensation (41%), such as salary or wages, incentives, and stipends. Initial training of CHAs varies widely in format, content, and intensity depending on the type of program and the functions expected of



the CHA. On the average, agencies provided 40 hours or fewer of initial training and 2-4 hours of in-service training per month. Over half (56%) of the respondents said their programs offered certificates of long-term training, via inservices, which provided additional health and community information and resources enabling CHAs to meet client needs.

Seventy-seven percent of the programs provided compensation. Those that used a CHA more than 10 hours per month were more likely to compensate. The average CHA works 40 hours or fewer per month. Wages ranged from \$5 to \$9 per hour. Other forms of compensation included child care, reimbursement for travel expenses, and advanced training. Few programs offered health or other worker benefits. This data was comparable to that of the National Community Health Advisor Study: 75% of CHAs reported being paid and of those paid, 70% were paid \$10 per hour or less.

A closer look at the remaining responses to this open-ended question yielded three themes related to agencies — working environment, standard operating procedures, and scope of work — which seemed to be critical in retaining CHAs.

Respondents indicated that agencies must provide a working environment in which CHAs feel respected as individuals and esteemed for their competence within their communities. One example of how an agency might acknowledge a CHA's worth to the team is to encourage him or her to participate in the development of program protocols and materials.

Respondents indicated the need for an effective communication protocol in the working environment that routinely would keep CHAs informed of program results, would encourage information sharing, and would foster team building and mentoring of CHAs by other staff members. They listed many ways of showing appreciation for CHAs, which included incentives, recognition awards and luncheons, specialized training courses, and certification. Respondents from many agencies reported that an initial orientation session and opportunities for continuing education are essential to a successful working environment.

Respondents reported that standard operating procedures that help retain CHAs are more people-centered than product-centered. Matching the CHA's skills with appropriate tasks, offering flexible work schedules, encouraging individual goal-setting, and offering leadership opportunities are standard operating procedures integral to retaining CHAs.

Examples of responses included in the scope of work variable were clear expectations, meaningful work, opportunity for development and advancement, group projects, fair work load, and clear standards for performance with a well-defined job description. Other research indicates that providing more realistic expectations of what the work entails is a significant factor in preventing worker burnout<sup>16</sup>.

## **Discussion**

CHA programs support public health efforts to solve complex problems, particularly those that disproportionately impact members of vulnerable populations such as racial and ethnic minorities and people with low incomes and poor education. The finding that 95% of CHAs are members of their target

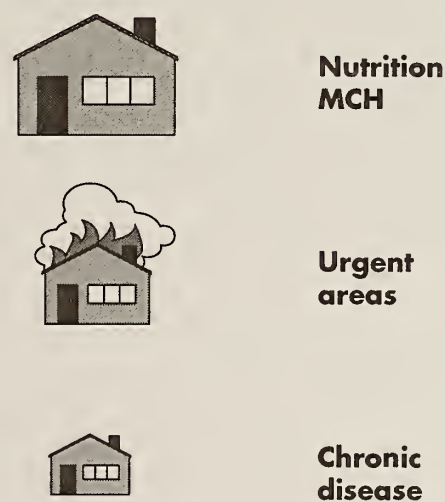
communities suggests that these types of interventions are delivered by indigenous members of these populations in a manner that is consistent with the local cultural beliefs, practices, and social norms. This can allow CHA programs to more effectively promote primary and secondary prevention messages and services and to increase access to health care access, thereby helping to fill in the gaps in the current health care system.

The finding that community groups such as local health departments, local social service agencies, and clinics operate most programs suggests that these organizations use existing social networks to promote health. CHAs also work through social networks, such as families, friends, neighborhood groups, churches, and worksites. CHAs thus link individuals and families with health and social services agencies in the community <sup>7,17</sup>, help health professionals understand the community’s priorities and health concerns, and promote positive, healthful behaviors among their neighbors <sup>1,18</sup>.

The survey results show that CHA programs reach all age, racial, and ethnic groups in the United States in both rural and urban areas. They serve a broader population than might be expected from reading the published descriptions of individual CHA programs. It is not surprising to see the large percentage of CHA programs that serve black and Hispanic populations. Research findings support the effectiveness of using the CHA strategy in these populations in which members operate through social networks and traditionally rely on informal health care networks <sup>4,5,19-26</sup>. However, the finding that a larger percentage of programs focused on white populations was unexpected. One explanation is that states with pre-dominately white populations submitted more surveys than did those with more diverse populations. Also, some programs, such as those located in rural Appalachia, primarily focus on poor, less educated white clients. We found that most CHA programs are open to all community members, regardless of their racial or ethnic background. Thus, respondents may have checked the category for whites on the survey even though their program primarily targets other groups. The low number of programs serving Native Americans may be due to the lower than expected response rate from Native American programs. We received a few responses from individual Native American programs and one response from the Indian Health Service office (representing over 1,500 Community Health Representatives in all IHS programs).

Over half of the programs integrate urgent public health topics into traditional health interventions involving maternal and child health, adolescent health, and college peer health interventions. These urgent topics included substance abuse (58%), sexual behavior (53%), HIV/AIDS (51%), tobacco control (46%), and violence (45%) (Figure 3). A smaller number of programs (25-30%) indicated that they address injury prevention, physical activity, and chronic disease control. Less frequently covered topics included mental health and health issues of the elderly (10%). These trends show that CHA

**Figure 3. Focus of CHA Programs**





programs are responsive to pressing contemporary public health issues. The significance of these trends is the diffusion of the CHA strategy from the traditional focus on maternal and child health and nutrition to newer issues in health promotion and disease prevention.

Our analysis indicates that the role of the CHA overwhelmingly involves health promotion and education rather than treatment. This finding is consistent with research results that show that throughout the past 25 years CHAs consistently have acted as resources for health information and have assisted with patient education<sup>26</sup>. One exception noted in the literature is the Community Health Aide in Alaskan Native American communities, who is trained and certified to deliver primary health care on a limited basis<sup>27,28</sup>.

## **Recommendations**

The results of this analysis suggest that agencies exploring the use of CHAs should consider several issues. First, agencies should develop a long-term training plan that includes orientation and continuing education, because they appear to be a critical component in retaining CHAs and contribute to program stability. A long-term training plan keeps CHAs interested in the program and allows them to vent their frustrations, share their experiences, and find creative solutions to problems they encounter.

Second, agencies should carefully consider whether to compensate CHAs. This issue is much debated among those involved in CHA programs and research. Some fear that compensation elevates CHAs to the level of paraprofessionals and possibly distances them from their community. Most respondents provided at least minimal compensation to CHAs who work more than ten hours per month, and 40% of the agencies felt that doing so helped them retain CHAs in their programs.

Third, agencies considering the use of CHAs should review their working environments. It is clear that those agencies that considered their programs successful do not view CHAs as a source of cheap labor but as valued members of the agency's team. A management approach that respects CHAs as individuals, respects their culture, provides support, remains trustworthy, and maintains open lines of communication enhances the CHA's self-esteem, effectiveness, and ultimately their willingness to stay with the program. Previous research has shown the value of teaching these concepts to agency staff and securing their acceptance of CHAs as integral team members<sup>20</sup>.

Fourth, agencies should plan a recruitment strategy that includes selection criteria for CHAs and methods of identifying appropriate candidates. This survey did not include the characteristics that are most valued in CHAs, but desirable characteristics have been documented previously<sup>1,8,23,29</sup>. The traditional methods of recruiting CHAs—word-of-mouth and networking referrals—are the most successful. Although these methods are labor intensive, they are reported as the most effective means of finding people who are already considered to be lay health advisors by their fellow community members.

The results of this analysis underscore a need for further study to determine the number of programs in the United States using community health advisors, the geographic distribution of such programs, the health-related issues they address, the characteristics of the agencies that operate them, and the methods of working with CHAs. This information would help in describing effective recruitment, training, and retention strategies and developing the best guidelines for working with CHAs.



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## Article 2

### **Roles and Competencies of Urban and Rural Community Health Advisors: Findings and Implications for Practice from the National Community Health Advisor Study**

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### **Abstract**

The Community Health Advisor (CHA) outreach model has been used to provide health services and education in underserved urban and rural areas of developing countries around the world. In 1996 the Annie E. Casey Foundation commissioned the National Community Health Advisor Study (NCHAS) to examine and define four critical areas pertinent to the future of the CHA field in the United States. This paper presents NCHAS findings which are relevant to urban and rural CHA roles, competencies, and career development issues. The NCHAS conducted a literature review and collected data from established CHA programs and CHAs in the field by conducting a survey of CHAs and CHA supervisors as well as site visits, interviews, and focus groups. NCHAS identified seven roles for CHAs and specific personal qualities, skills, and abilities of effective CHAs. Differences between urban and rural CHAs are discussed. Recommendations are presented for addressing barriers to career advancement and role definition for CHAs.

### **Introduction**

For many years in the United States, both public and private health agencies and organizations have conducted health promotion and disease prevention campaigns. Despite intense efforts, a wide chasm continues to exist between the U.S. health care delivery system and members of many vulnerable



populations the system seeks to serve. The passive medical model — in which providers wait at clinics for patients to arrive seeking help — is not effective for many reasons — some of them are cultural and many of them are economic.<sup>1,2,3</sup> For example, in areas where free immunizations have been offered, immunization rates have nevertheless remained low. Where prenatal care has been available and affordable, it has not been used according to professional standards. Additionally, the recent trend toward a managed health care system has not only shifted the provision of care for many persons supported by health care programs (e.g., Medicaid and Medicare) to managed care providers, but also put the burden of proof of need on providers and patients. Furthermore, managed care providers recognize that reduced financial barriers will not necessarily ensure that persons eligible for care will access appropriate services in a timely manner.

To overcome barriers to health care, persons who deliver health promotion and disease prevention programs and health care services must seek responsive and creative solutions. One solution is to involve local community members in community outreach that may provide transportation, child care, information, translation to languages other than English, and an attitude toward health that goes beyond treatment of acute illness.

One validated, effective, and inexpensive outreach model is the Community Health Advisor (CHA) model, which is not a new concept.<sup>4-12</sup> The model, which has been used to provide health services and education in underserved urban and rural areas of developing countries around the world, is exemplified by the Barefoot Doctor program in China. By the 1980s the CHA was generally a member of the target community who understood the community's health needs and concerns, was respected locally, had access to and influence with community members, and provided a cultural and linguistic bridge between community residents and health and human services professionals.<sup>10-12</sup> As health care systems have changed, emphasis is given to preventive, primary, and managed care and has increased interest in using CHAs to deliver community health services (e.g., referrals, education, and social support).

Various titles are used to name Community Health Advisors including Lay Health Advisors, Promotoras, Lay Health Workers, Community Health Workers, Community Health Representatives, and Peer Health Educators.<sup>6,12</sup> These varied titles reflect the diversity of community health program goals, funding resources, and geographical locations but do not adequately describe the fluid roles of CHAs.

The number of CHAs in the United States is unknown. The most comprehensive documentation of CHA programs is found in the Centers for Disease Control and Prevention's (CDC) Combined Health Information Database, which contains profiles of over 200 programs representing more than 12,000 CHAs. The largest program, the Indian Health Service's Community Health Representatives (CHR) Program, has 1,500 CHRs.<sup>6</sup> The growth in CHA programs outpaces CDC's efforts to update the database, which depends on the voluntary submission of program information.

In 1996 the Annie E. Casey Foundation commissioned the National Community Health Advisor Study (NCHAS) to examine and define four critical areas pertinent to the future of the CHA field. These areas are: CHA core roles and competencies, evaluation strategies for CHA programs, career advancement for CHAs and the field as a whole, and CHA's role in the changing health care system. The aim of NCHAS was to address critical policy and program issues so that CHAs can continue to provide services to

community members in need. This paper presents NCHAS findings, which are relevant to urban and rural CHA roles, competencies, and career development issues.

## Methods

The NCHAS collected data from established CHA programs and CHAs in the field. The research was guided by the Federal Technical Advisory Committee, members of the American Public Health Association's New Professionals Special Primary Interest Group, NCHAS staff and consultants, and the NCHAS Advisory Council. The Advisory Council consisted primarily of CHAs, but also included program supervisors and CHA advocates. The Advisory Council assisted in interpreting qualitative data, reviewed the results, developed recommendations, and reviewed the final report.<sup>12</sup> A Readers Panel, composed of CHA researchers and other professionals and practitioners working in related fields, also reviewed our findings and recommendations.

Both qualitative and quantitative data were collected by contacting CHA practitioners and researchers to obtain unpublished and published program evaluations, core competency curricula, and other materials. We also reviewed the CHA literature relevant to the study's four core areas.

### *CHA and CHA Supervisor Survey Sample and Methodology*

NCHAS staff and consultants developed a survey instrument that probed for information about programs and the four core areas of the Study. A random survey was not possible since not all CHA programs could be identified. Thus we surveyed a nonprobability, convenience sample of CHA and CHA supervisors and consequently inferences can be made about respondents only and not all CHAs and CHA supervisors in the United States. The draft survey was pilot-tested among practitioners who were participants of the 1996 Arizona Statewide Community Health Advisor Training Conference. To obtain a representative sample of CHAs the final survey was distributed at several conferences and training sessions and mailed to more than 80 U.S. programs. Responses were received from 150 programs from 29 states. The survey was completed by 281 CHAs (82%) and CHA supervisors (33%); 67% of the supervisors were also working as CHAs.

### *Site Visits, Interviews, Focus Groups*

In addition, data were collected during 12 program site visits conducted by NCHAS staff and consultants. During some visits, focus groups with CHAs were supplemented by interviews with supervisors and other staff and clients. The programs differed by type of health area covered and target population addressed.<sup>7</sup> Focus group and interview data were the primary qualitative data source for several components of the study.

### *Data Analysis*

Staff at the University of Arizona's Rural Health Office coded and entered survey data and CDC staff analyzed the data by using SAS software. Response variables for the open-ended questions survey



questions and individual and focus group interviews were generated by sifting data for common themes (i.e., the constant comparative method of qualitative data analysis developed by Strauss and Corbin).<sup>13</sup>

## Results

### *Literature Review and Historical Perspective*

Most of the early U.S. literature about CHAs comes from urban programs, many of which were founded as a part of the War on Poverty by the Office of Economic Opportunity (OEO). Table 1 presents an overview of the terms used, roles played, and competencies possessed or developed by CHAs in a convenience sample of U.S. urban programs from the 1960s and 1970s. These programs were quite diverse. For example, in the Denver (1) and Tulsa (4) programs, CHAs had creative and responsible roles educating the community about the health care system and vice versa, and in influencing the ongoing design of programs. Advocacy was an explicit role of the CHAs in both programs, and in the Denver project, community organizing was another role.<sup>14,15</sup>

The workers in both the Washington, DC (2), and Los Angeles (3) projects were called “aides” and their roles were circumscribed. In Washington, DC, the aides were hired “to alleviate a shortage of professional health educators—rather than because of any unique skills they might possess.”<sup>16</sup> Consequently, aides were required to have a high school diploma and two years’ experience in the health field. The goal of the Los Angeles program was to determine whether aides could be as successful as professionals in counseling parents about iron deficiency anemia. Entrance requirements and training were minimal.<sup>17</sup> The Kaiser Permanente Neighborhood Health Center Project (5) was one of the first CHA projects sponsored by a health maintenance organization (HMO). It foreshadowed some of the roles and skills that managed care organizations foresee for CHAs. For example, recruitment of new plan members and management of services used were responsibilities of the CHAs in the project.<sup>18</sup>

Several similar competencies were sought by or developed in all five programs. These competencies included communication skills, a relationship with the community, and knowledge of the community and the health care system, and the workers were paid.

Literature from the mid to late 1980s describes the development of rural CHA programs, many of which were strongly influenced by the literature and experience from CHA programs in the developing world. These programs did not require academic competency (e.g., a high school diploma) and emphasized personal qualities, such as natural leadership skills and community respect. In the literature rural lay health advisors (LHAs) were distinguished from urban outreach workers, who were characterized as “stopgap measures used to respond to a shortage of trained personnel.”<sup>19</sup> Personal qualities sought in the rural LHAs and promotoras included community membership, inquisitiveness, and a willingness to help others by sharing information.<sup>11</sup> Being bilingual and biliterate was also viewed as important since many of the rural projects targeted Hispanic migrant communities.<sup>20</sup> The rural workers provided health education, advocacy, and referrals; conducted case finding; negotiated the health care system; linked people with services; counseled clients; and organized communities.<sup>11,20</sup>

**Table 1. Titles, roles and competencies of CHAs in a sample of early U.S. programs**

<b><i>Program Name and Date*</i></b>	<b><i>Title Used</i></b>	<b><i>Roles and Responsibilities</i></b>	<b><i>Qualities and Skills**</i></b>
1) Denver, CO, Maternity and Infant Project (1967)	Neighborhood representatives	<ul style="list-style-type: none"> <li>• community organizing</li> <li>• linkage</li> <li>• mediation</li> <li>• advocacy</li> </ul>	<ul style="list-style-type: none"> <li>• identification with target group</li> <li>• communication skills</li> <li>• accepted as neighborhood member</li> <li>• possess work ethic</li> <li>• value health care</li> <li>• be socially mobile</li> <li>• women over age 35</li> </ul>
2) DC Department of Health MCH Project (1968)	Health education aides	<ul style="list-style-type: none"> <li>• home visits</li> <li>• provision of educational materials</li> <li>• motivation to seek care</li> </ul>	<ul style="list-style-type: none"> <li>• high school diploma</li> <li>• 2 yrs. appropriate experience</li> <li>• knowledge of the concept of public health</li> <li>• knowledge of MCH issues and health care system</li> </ul>
3) LA County General Hospital Project (1969)	Indigenous health aides	<ul style="list-style-type: none"> <li>• health education about iron deficiency anemia</li> </ul>	<ul style="list-style-type: none"> <li>• high school graduate</li> <li>• knowledge about nutrition (importance of iron-rich diet)</li> </ul>
4) Tulsa, OK, Immunization Project (1970)	Indigenous personnel	<ul style="list-style-type: none"> <li>• home visits</li> <li>• health education</li> <li>• motivation</li> <li>• education of health care system</li> </ul>	<ul style="list-style-type: none"> <li>• frequent recommendation by expert informants</li> <li>• ability to conduct survey work</li> <li>• understanding of: the rationale of the project, the health dept. and clinic systems, and communicable diseases and immunizations</li> </ul>
5) Kaiser Permanente Neighborhood Health Center Project (1979)	Outreach worker, neighborhood health coordinator	<ul style="list-style-type: none"> <li>• recruitment</li> <li>• health education</li> <li>• management of services used</li> <li>• referral to community resources</li> </ul>	<ul style="list-style-type: none"> <li>• meet OEO income criteria</li> <li>• indigenous to community</li> <li>• communication skills</li> <li>• understanding of the importance of preventive services</li> <li>• understanding of health care and health education concepts</li> </ul>

\* Dates refer to publication date of cited article.

\*\*Competencies include both recruitment criteria and skills taught in the program.

### *Roles of Community Health Advisors*

In focus groups with CHAs and interviews with CHA supervisors, we found examples of rural and urban CHAs who play all of the following roles: 1) bridging communities and the health and social service systems, 2) providing culturally appropriate and accessible health education and information, 3) ensuring that people received the services they need, 4) providing informal counseling and social support, 5) advocating for individual and community needs, 6) providing direct service, and 7) building individual and community capacity. Each of these roles includes several functions, which are delineated in the NCHAS report.<sup>12</sup>

Community organizing occurred in urban and rural CHA programs. At the Codman Square Health Center in Boston, for example, the service area was divided geographically, and a community health worker was assigned to each zone. The workers surveyed to identify, and then worked with community members to resolve important community issues. CHAs at Seattle's People of Color Against AIDS Network (POCAAN) used the title community organizer. CHAs' role as community organizers has also been emphasized by academics and developers of rural LHA programs.<sup>5</sup>

In both rural and urban programs some CHAs function both for the community and the health care system. Community Health Promoters (CHPs) from La Familia Sana, Inc., an independent CHA agency in Hood River, Oregon, regularly facilitated cultural competence workshops for medical and nursing students. CHPs employed by the Midwest Migrant Health Information Office presented similar workshops for staff at clinics in Texas. Community organizers from POCAAN provided employee training in recognizing and resolving homophobia among workers at urban clinics and hospitals.

The breadth of the role assigned to CHAs did not depend on whether the program was rural or urban. In some rural areas, culturally competent mental and physical health services are either nonexistent or very limited.<sup>22, 23</sup> Community need and program philosophy determined how broad the role may be. Thus, CHAs (e.g., La Familia Sana, Inc.) facilitated cultural competence workshops as well as taught health education classes, advocated for battered women's rights in the court system, conducted a treatment program for men arrested for domestic violence, and led a support and education group for women with diabetes. Urban workers also frequently play a variety of roles, both because of a lack of services and because of the level of trust they often develop with clients. Although she was uncertain about the appropriateness of CHAs providing counseling, the Co-Director of Seattle's Birth to Three Program agreed that the role was often unavoidable. "I mean, it is a fine line because . . . they are not counselors per se," Gengler stated. "On the other hand, [for] the women they work with . . . trust is such an issue and it is so difficult to develop. . . But then they [CHAs] can also be a bridge to those other professionals."

The only difference we identified between the responsibilities of rural and urban CHAs involved the amount of provision of clinical service. Rural CHAs (e.g., the Camp Health Aides and promotoras de salud employed by the Midwest Migrant Health Information Office) tended to increase access to care by providing more clinical services such as first aid and health screenings in homes and migrant labor camps. Urban CHAs tend to provide clinical services in programs having a specific focus (e.g., blood pressure measurements in hypertension programs and foot care in diabetes programs).



## *Competencies of Community Health Advisors*

To be effective in their work, both rural and urban CHAs need specific personal qualities, abilities, and skills (Tables 2a and 2b). We defined qualities as personal characteristics that can be enhanced but not taught, and skills as learned abilities. Personal qualities such as friendliness, open-mindedness, empathy, and respect allowed CHAs to build the trusted relationships on which their work depends. Patience, flexibility, and persistence helped them deal with and surmount the barriers to care faced by their clients. Initiative and reliability enabled them to carry out complex and self-directed work. Their effectiveness as role models depended on their honesty and willingness to grow and change.

In our interviews and focus groups, both urban and rural CHAs and CHA supervisors agreed that a relationship to the community is one of the most important qualities of a CHA. An urban CHA from Seattle stated that, “[as] an outreach worker, you come from your community and people look at you as a model.” A rural CHA from Oregon echoed this sentiment, saying that, “[we] need to have lived, to have experienced what the community has lived.”

**Table 2a. Qualities of effective CHAs reported by respondents to the NCHAS survey**

<b>Quality</b>	<b>Frequency</b>
Friendly/outgoing/sociable/personable/like people/able to develop rapport	82
Patient	56
Open-minded/non-judgmental	55
Possessing initiative or motivation/self-directed/self-starter/independent/hard worker	50
Caring	44
Empathetic	44
Committed/dedicated	43
Respectful	41
Honest	39
Open/eager/able to grow/change/learn	31
Dependable/responsible/reliable	31
Compassionate	28
Flexible/adaptable	26
Desire to help people and/or community	24
Persistent	23
Creative/resourceful	23

\* N = 281. Ten spaces were provided for answers to this question; some respondents provided more than ten. Percentages are not reported because of occasional double-counting of respondents.

**Table 2b. Skills and abilities of effective CHAs reported by respondents to the NCHAS survey**

<i><b>Quality</b></i>	<i><b>Frequency</b></i>
Communication skills (general and speaking skills)	192
public speaking skills	
conflict resolution skills	
ability to use appropriate language	
interviewing skills	
Listening skills/attentiveness	103
Knowledge about health issues and/or the health care system	72
Writing skills	63
ability to fill out forms	
ability to write reports	
ability to keep records	
Ability to identify and access resources	54
Capacity-building skills	54
leadership skills	
empowerment skills	
Cultural sensitivity/ability to work with diverse classes and cultures	52
Bilingual skills	50
Knowledge about the community	48
aware of needs, problems, issues, dynamics	
Organizational skills	44
ability to set goals/priorities	
ability to plan	
time-management skills	
Preparation/being well-trained	36
Ability to maintain confidentiality/discretion	31
Ability to work in a group/as a team member	30
Clinical skills	27
ability to take vital signs	
ability to recognize signs of illness	
ability to administer first aid	
Networking/coalition-building skills	22

\* N = 281. Ten spaces were provided for answers to this question; some respondents provided more than ten. Percentages are not reported because of occasional double-counting of respondents.

However, urban and rural CHAs and program staff differed in how they characterized the CHAs' relationship to the community. Staff in rural programs tended to define community membership in terms of race or ethnicity and social class, while staff in urban programs defined it in terms of shared experience. For example, the Research Advocates (CHAs) in Seattle's Birth to Three Program must have "something in their background . . . that allows them to directly relate to clients." But that something can be the experience of being a recovering alcoholic, and clients are not assigned to advocates on the basis of race or ethnicity.

Urban programs also tended to emphasize the ability to relate across cultures, fit into the surroundings, and use appropriate language. Many urban CHAs gave examples of situations in which they were able to work effectively across cultures. Some CHAs stated that clients of other races preferred to work with them rather than with someone from their own ethnic group. A staff member at San Francisco's Institute for Community Health Outreach spoke for many urban program developers:

We do not see CHAs as natives with innate skills. We see them as professionals who have skills that enable them to be culturally competent so that they can work with diverse communities. For instance, certain sex workers may need a woman outreach worker, or new immigrants may need someone who is a fluent speaker of their language. But gay/lesbian Asian Americans may be more comfortable talking to someone from outside their community because the outreach worker may know their family.

Our survey revealed a difference between the percentage of urban CHAs (60%) and rural CHAs (85%) who matched their clients in race or ethnicity. Rural CHAs tended to work in isolated, homogenous communities. Most community members in a given program were immigrants from just three or four Mexican states. In most urban areas a multicultural, multiethnic environment made it more likely that CHAs worked with diverse populations. For example, the community organizers at Seattle's POCAAN work with clients who are American Indians, blacks, Asian or Pacific Islanders, Hispanics, whites, or of other racial or ethnic backgrounds.

According to participants in our interviews and focus groups, both urban and rural CHAs also need a set of skills for (1) communication, (2) interpersonal relations, (3) service coordination, (4) capacity-building, (5) advocacy, (6) teaching, and (7) organizational activities. CHAs also needed to understand community needs, the health and social service systems, and health issues. All these skill and knowledge categories are explained fully in the NCHAS report.<sup>12</sup>

For several decades, the CHA field has provided an entry point into both the paid and volunteer workforce for many persons in low-income communities who want to serve long-term as CHAs or who want to begin a career path toward other professions. In isolated, rural communities CHA programs offer a unique opportunity for professional development for both paid and volunteer CHAs. CHAs gain access to training and an outlet for community service. Because access to other such opportunities may be limited many CHAs expressed strong interest in continuing to serve long-term. In focus groups, both paid and volunteer CHAs in rural communities often said that they saw the CHA's work as professional work. Both urban and rural survey respondents also saw the CHA role as professional (81%). Also, over 80% of both rural and urban paid and volunteer CHAs held this point of view. However, for many



urban CHAs, the position was a step in a career path to another profession. During site visits we noted that more urban than rural CHAs are pursuing college degrees. However, some urban CHAs want to remain CHAs and sensed that their role must be better recognized and understood so that they can carry out their work more effectively. Both rural and urban CHAs were frustrated with a lack of career development opportunities within CHA programs. Barriers to career advancement that the NCHAS identified were lack of standardized training and lack of credit for training. Survey respondents supported voluntary certification (71%) and standardization of CHA training (77%); and focus group members were also supportive of these types of efforts.

We found significant differences in the financial status of rural and urban CHAs. A smaller percentage of rural (74 %) than urban (90%) CHAs were paid and the average wage for paid rural CHAs was much lower than that for urban CHAs. Seventy-one percent of the rural programs paid less than \$10 an hour, but only 27% of the urban did so. No paid urban CHA made less than \$5 an hour but 26% of paid rural CHAs did. These salary differences may be related to available resources; local funding was less for rural than urban programs. Rural programs obtained 11% of their funding from local private sources, while urban programs received 26% of their funding from these sources. Only 1% of rural programs but 15% of urban programs had local public funding. Forty-eight percent of the urban CHA programs and 13% of the rural programs indicated that their programs had managed care contracts. Differences in funding levels may relate to other program factors; the median number of hours worked per week was 15 by CHAs in rural areas and 36.5 in urban areas.

## **Discussion/Implications**

Our review of the U.S. literature about CHAs reveals some differences between rural and urban CHA programs. However, the roles played by and competencies sought in CHAs tended to depend on the underlying philosophy of the program. If, as in the Denver project, workers were seen as community experts who could and should be doing program planning, then a specific set of skills and qualities were sought. If, however, workers were seen as aides or extenders then academic skills and the ability to integrate into the system were emphasized.

Our findings present clear implications for the development and management of urban CHA programs. Even in urban areas that have more health and human services available relative to rural areas, CHAs play many roles. Therefore, CHA training needs to be broadly-based; encompass physical, mental, and psychosocial health; and must be responsive to CHAs' changing needs. At the same time the boundaries of CHAs responsibilities need to be clearly articulated.

Urban CHAs will no doubt continue to work with clients from many different racial and cultural groups. Therefore, the ability to relate to people of different cultures should be emphasized in the recruitment and training of urban CHAs. Further, community membership should be defined broadly in urban CHA programs because experience may contribute more than race or ethnicity to a CHA's credibility and ability to relate to clients.

CHAs who have an intimate understanding of the communities in which they work are uniquely able to address basic determinants of health including food, shelter, employment, education, respect, and



dignity. CHA services differ from traditional medical services, which some say “have had little success in addressing these determinants of health.”<sup>21</sup> A limited role for CHAs prevents them from making this unique contribution. Rather, CHAs must be integrally involved in program planning and evaluation and they should be given opportunities to share their knowledge with other members of the health care system. CHAs’ role in advocacy and community mobilization should be emphasized in urban programs.

Part of the explanation for why urban CHAs tended to be paid and rural CHAs were not, lies in the ways their roles have been defined. Since the 1960s, urban CHA jobs have been seen as entry-level positions that offer residents a way out of poverty and or a first step up a career ladder. Payment of salary was never questioned. In contrast, rural programs were influenced by models from the developing world where CHAs were rarely paid. (In some of these programs, however, CHAs receive in-kind payment from neighbors who plant or harvest the CHAs’ crops or offer other support.) In many rural programs, workers are expected to continue to migrate or do farmwork and share health information in the course of their daily life. Some concern has been expressed that if CHAs are paid, their connection to the community will be compromised, and they will be seen as a member of the “system.”

Both rural and urban programs can establish career paths in order to retain CHAs and support their career development. In one path, CHAs become specialists in a given health area (e.g., diabetes, maternal and child health, cardiovascular disease). Another approach is to create different jobs within programs (e.g., CHA supervisor, in-service trainer, training coordinator, or training specialists). To address barriers to CHA career advancement, NCHAS recommends adoption of common standards for core roles and competencies and related curriculum guidelines.<sup>12</sup> NCHAS also recommends voluntary national certification of CHAs.<sup>12</sup> These would aid in establishing the boundaries of CHA roles and in helping CHAs achieve their personal goals.

The primary role of CHAs is usually defined within the medical model as case-finding-bringing people into the system for screening, education, and treatment; delivering health promotion messages, and providing support to clients in homes and community settings. Discussion is ongoing among practitioners as to whether CHAs should also be community change agents, whether their goal is empowerment, and whether they are primarily motivators rather than educators. The consensus among CHAs themselves is that they serve all these functions.

The role of the CHA continues to evolve in response to the communities in which they live. CHAs generally remain members of the community they serve but they are selected and supported by the health care system according to its needs. The relationship between the community and the contemporary role of CHAs mirrors the paradigm shift from helping to health care.

The uniqueness of NCHAS is its focus on the practitioners — CHAs and their supervisors. They contributed as members of a policy participatory research project as focus group participants and survey respondents to give meaningful insights into CHA programs and program issues. Additionally, as members of the NCHAS Advisory Board, they played an instrumental role in formulating recommendations that aim to promote and strengthen the CHA profession and field.<sup>12</sup> The involvement of CHAs lends authenticity to the study of this field. CHAs collaborating on NCHAS have become united. They

are newly committed to forming regional coalitions and a national organization. They feel strongly that it is their time to be recognized, as evidenced by the renewed interest in the CHA field from managed care organizations; funding agencies; local, state, and federal governmental agencies; and special interest groups. As one worker said at the 1996 American Public Health Association Meeting, "We have worked tirelessly in what seems at times a thankless job. We have paid our dues and it is now time that our value is recognized and acknowledged as a viable member of the health care and services delivery team."

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## Introduction

### *What does this publication contain?*

*Community Health Advisors/Workers: Selected Annotations and Programs in the United States, Volume III* contains bibliographic abstracts of journal articles, reports, literature, resource materials, and program descriptions from the 1970s through the present. These entries were selected to provide information to community health advisors with models, research, practice information, and health promotion and disease prevention programs on subjects such as breast and cervical cancer, heart disease, hypertension, nutrition, physical activity, pregnancy and prenatal care, and smoking prevention. Items were obtained by searching computerized bibliographic databases and by contacting organizations currently conducting programs involving the use of community health advisors. Items also are listed in the Health Promotion and Education Database and the Cancer Prevention and Control Database, subfiles of the Combined Health Information Database (CHID).

### *What is CHID?*

CHID is a computerized bibliographic database of health information and health promotion resources developed and managed by several federal agencies. This unique reference is for all health professionals who need to locate health information for themselves or their clients. Current CHID producers include the Centers for Disease Control and Prevention, the National Institutes of Health, the Office of Disease Prevention and Health Promotion, and the Health Resources and Services Administration.

### *How can I access the databases?*

CHID and its subfiles, the Health Promotion and Education Database, the Cancer Prevention and Control Database, the Epilepsy Education and Prevention Activities Database, and the Prenatal Smoking Cessation Database are available for online searching through the Internet at <http://chid.nih.gov>. The databases also are available through *CDP File*, a CD-ROM produced by CDC's National Center for Chronic Disease Prevention and Health Promotion.

### *Where can I get more information?*

Should you need for information on the database, *CDP File*, or CHID; wish to submit materials for possible inclusion in the databases; or need additional copies of this publication, contact:

Technical Information and Editorial Services Branch  
Centers for Disease Control and Prevention  
4770 Buford Hwy, NE, Mailstop K-13  
Atlanta, GA 30341-3717  
(770) 488-5080



*Questions on programmatic issues may be directed to:*

J. Nell Brownstein, Ph.D.  
Division of Adult and Community Health  
National Center for Chronic Disease Prevention and Health Promotion  
Centers for Disease Control and Prevention  
4770 Buford Hwy, NE, Mailstop K-45  
Atlanta, GA 30341-3717  
(770) 488-5440  
jnb1@cdc.gov

# How to Use This Publication

## *Arrangement of Items*

Items in this publication are arranged in two sections, Selected Annotations (Section I) and Programs in the United States (Section II). Within each section there are several subsections arranged by subject. Items in each part are listed in alphabetical order by title. The items are numbered sequentially, beginning with 001.

## *Indexes*

This publication contains three indexes for each Section. For Section I, the *Title Index* lists document titles, the *Author Index* lists personal and corporate authors, and the *Subject Index* lists selected key words describing the content of publications. For Section II, the *Title Index* lists program titles, the *Program Coordinator Index* lists program directors and program contacts, and the *Subject Index* lists selected key words describing the content of programs. If you know the title of a publication or program, use the *Title Index*. If you are looking for a publication produced by a person or agency, use the *Author Index*. If you are looking for a program conducted by a particular person, use the *Program Coordinator Index*. If you want to identify items in a specific subject area, use the *Subject Index*.

## *Data Elements*

A citation and abstract are listed for each item in this publication. Data elements for Section I include the item number, title, form, author or corporate author, source and availability when noted, abstract, and CHID accession number.

012

**Bringing Providers to the People: Alaska and a Florida County Blaze New Trails in Non-Physician Care Delivery.**

**Form:** Journal article.

**Author:** Sherer, J.L.

**Source:** Hospitals and Health Networks. 68(3):56, 58, 60, February 5, 1994.

**Abstract:** A health professional describes Alaska's Community Health Aide Program, which trains village residents to deliver emergency and primary preventive care to villagers who live hundreds of miles from the nearest hospital and physician. Volunteers used by the federal government to dispense medications during the tuberculosis epidemic in the 1950's eventually became known as community health aides (CHA's). Today, more than 400 CHA's, village residents who are selected by

members of the community, provide health care to 45,000 people in Alaska's 171 villages. CHA's must have at least a sixth-grade reading level and knowledge of math. They participate in a 4-month session of classroom instruction and skills practice to learn basic history taking, physical assessment, and diagnostic skills. Before they begin practicing independently, they must complete 2 to 3 years of clinical observation by physicians. The state contributes \$2 million annually in training funds to the CHA project, but most funding comes from the Indian Health Service, a federal agency that delivers and oversees care through Alaska's 12 Native Health Corporations. The CHA program has brought about a dramatic improvement in the Alaskan population's health status over the past decade, prompting marked declines in cases of hepatitis B, gonorrhea, and rheumatic fever. Health officials in Pinellas County, Florida, have proposed that the county follow Alaska's lead by expanding their own emergency medical

personnel and allowing paramedics to deliver primary health services to the indigent. Officials have been unable to implement the program, however, because of

practice and licensing laws and other barriers.  
(HE9700078)

Among the data elements included for Section II are the program name, program contact, agency, program dates, health topics addressed, target population, and CHID accession number.

	204
<b>Program</b>	• <b>Breast and Cervical Cancer Education.</b>
<b>Contact</b>	• Carcar, Noemi.
<b>Agency</b>	• Mercy Mobile Health Care, 60 11th Street, Atlanta, GA 30309. (404) 249-8104.
<b>Program Dates</b>	• March 1995–continuing.
<b>Delivery Sites</b>	• Homes, community sites, hospital/medical clinic.
<b>Funding Source(s)</b>	• Fannie Mae Foundation, Avon Foundation.
<b>Primary Purpose</b>	• To educate low-income Hispanic and Asian American women about early detection of breast and cervical cancer to make referrals for clinical examinations.
<b>Services Offered</b>	• Patient outreach and education, cancer detection tests.
<b>Materials Used</b>	• Shower cards, handouts/brochures, breast model, cervix model.
<b>Health Topic(s) Addressed</b>	• Breast and cervical cancer.
<b>Geographic Area/Unit</b>	• Multicounty.
<b>Program Setting</b>	• Community-based agency, religious institution, hospital.
<b>Target Population</b>	• Low-income Hispanic and Asian American women living in a five-county area in Georgia.
<b>CHA Title</b>	• Outreach worker, resource specialist.
<b>CHA Roles</b>	• Outreach, health promotion/education, follow-up.
<b>CHA Training</b>	• 40 hours of initial training and 1 hour per month of inservice training.
<b>CHA Compensation</b>	• \$8.50 per hour plus health insurance, tuition reimbursement, and mileage reimbursement.

*Number of CHA's* • 3.

*Number of Clients  
Served in 12 Months* • 1,053.

*Evaluation Plan* • Yes.

*Methods Used to  
Recruit CHA's* • Networking with community-based organizations, internal posting of  
job opportunities, word of mouth.

*Methods Used to  
Retain CHA's* • Educational opportunities, health benefits.

*Methods Used to  
Recruit Clients* • Outreach/education, clinical services.

*Methods Used to  
Retain Clients* • Case management follow up, employee dedication and persistence.

*CHID Accession Number* • CP96P0481.

### *Obtaining Additional Information*

This publication provides source and availability information for each item when noted. For more information about a program or publication, contact the agencies or persons listed.





# **SECTION I**





# The Community Health Advisor/Worker

## Conceptual Models

001

### **Community Health Workers: Integral Members of the Health Care Work Force.**

**Form:** Journal article.

**Authors:** Witmer, A.; Seifer, S.D.; Finocchio, L.; Leslie, J.; O'Neil, E.H.

**Source:** American Journal of Public Health. 85(8):1055-1058, August 1995.

**Abstract:** The authors describe the role of the community health worker (CHW) in the changing health care delivery system. CHW's are broadly defined as community members who work almost exclusively in community settings and who serve as connectors between health care consumers and providers to promote health among groups that have traditionally lacked access to adequate care. Historically, partnerships have formed with community-based care systems such as community and migrant health centers, homeless health care programs, and public health departments. More recently, CHW programs have developed partnerships with academic medical centers and managed care organizations. CHW's have contributed to the delivery of primary and preventive care by increasing access to health care for high-risk populations in underserved areas, improving the quality of care, reducing the costs of care, and contributing to community empowerment and growth. Barriers to the use of CHW's include (1) the lack of a standard definition and conceptualization of who CHW's are and what they do, (2) the lack of legitimacy granted to CHW's by degreed health professionals, and (3) the lack of secure funding. Recommendations for strengthening and expanding the use of CHW's include (1) creation of a national forum of CHW programs

and a national clearinghouse to facilitate the dissemination of information to policymakers, health care delivery organizations, and developing programs; (2) development of a CHW/community partnerships grant program with funds from federal or private organizations to expand and strengthen existing programs and create new ones; (3) provision of federal government funds for basic research on CHW's and randomized trials of CHW interventions; and (4) creation of opportunities for continuing education, professional recognition, and career advancement for CHW's. 37 references. (HE9600948)

002

### **Community Outreach and Community Mobilization: Options for Health at the U.S.-Mexico Border.**

**Form:** Paper.

**Author:** Meister, J.S.

**Source:** Phoenix, AZ, Arizona Department of Health Services, 10 p., April 1996.

**Abstract:** This paper offers a rationale for specialized efforts to increase health care access along the U.S.-Mexico border. The author argues that two models, community outreach and community mobilization, can be implemented successfully. Community outreach programs aim to overcome problems such as lack of transportation or child care, lack of information, lack of fluency in English, and a view of health and illness that defines care as appropriate for treatment of acute or emergency care only. The most highly developed community outreach model is usually referred to as the promotora, or community health advisor. Community mobilization models

stress high participation by community members and are generally based on the idea that health, including access to health care, is a systemic problem and the solutions must be systemic. The models incorporate outreach and enable community members to educate themselves about health problems and solutions and then bring about changes in community norms and practices. The proposed program will use volunteer community health advisors to focus on family-based individual problems within the community. The integration of these two models, both focusing on health care access issues, would be a natural development in attempts to improve the quality of life on the border. The models can be joined by the inclusion of outreach specialists into the community mobilization type of program. The author concludes that integration of the community outreach and community mobilization models, coupled with emphasis on seven thematic issues, can work to increase access to health care services in the U.S.-Mexico border region. This seven issues are: (1) culture of the border, (2) professional/community interface, (3) indigenous leadership, (4) expanding the definition of health, (5) immigration/migration, (6) transborder use, and (7) economic development. (HE9700617)

003

### **Conceptual Framework for Consideration in the Utilization of Health Aides.**

**Form:** Journal article.

**Author:** Callan, L.B.

**Source:** American Journal of Public Health. 61(5):979-987, May 1971.

**Abstract:** The author modified the School Health Education Study Model (SHES) to develop a conceptual framework for use in health programs, focusing initially on the use of indigenous aides. The author discusses the

steps an organization should follow to determine whether to use health aides. An accurate, realistic identification of needs is critical. Planning requires (1) an articulated goal, (2) assessment of resources, (3) commitment to meet the need, and (4) establishment of priorities. The next step is aide employment. A functional analysis should establish (1) what needs to be done, (2) what the purpose is, (3) who might best perform the tasks, and (4) how the tasks can best be performed. A job description should use based on this analysis. The next step is recruitment, selection, and training of the aide. Pretraining of potential supervisors is essential. Vital keys to the success of any training program are the selection of faculty and implementation and evaluation of the training, which depends on the terms of the job description and/or entry level of each employee. It may involve a combination of academic training, on-the-job training, weekly meetings with the project director, and quarterly seminars attended by all the aides and supervisors. Supervision is another important process. The supervisors' assumptions can lead to successful accomplishment of organizational and individual goals. The selected supervisory style should be a reflection of how an individual would prefer to be supervised himself. Other important considerations are when and how often supervision can be exercised and communication within the supervisory framework. A final important process is evaluation. To accurately evaluate the program, one must consider the goals of the endeavor to judge quantitative results in light of changed behavior and new behavioral practices. The author concludes that not all health program personnel are equipped to involve aides in their programs and that the use of aides would be unsuitable in some health agencies and organizations. 2 figures, 24 references. (HE9700310)



004

**Enhancing the Role of Community-Health Workers in Research.**

**Form:** Journal article.

**Authors:** Hill, M.N.; Bone, L.R.; Butz, A.M.

**Source:** IMAGE: Journal of Nursing Scholarship. 28(3):221-226, Fall 1996.

**Abstract:** The authors discuss the need to enhance the role of community health workers (CHW's) in research. With the shift to more primary care, CHW's should be an integral part of health care teams, yet they are often overlooked. They can serve as cross-cultural agents and liaisons among the community, the health care system, and academic institutions and can enhance investigators' access to community leaders, resources, and study populations. Thus, they enrich the comprehensiveness of a holistic scientific approach to understanding health in a community. CHW's can assume one or more of the following roles: (1) research assistant, (2) recruitment coordinator, (3) data collector, (4) interventionist, and (5) project coordinator. Successful integration of the CHW's into the research team requires addressing (1) position characteristics, (2) selection criteria and process, (3) training, (4) supervision, (5) retention, and (6) capacity building and career development. Before deciding to use CHW's in research projects, administrators should be aware of the challenges and costs involved in the use of CHW's, such as differences in academic and community priorities and balancing research productivity with CHW performance and career development. The benefits of using CHW's (volunteer or paid) in research are (1) increased cultural sensitivity, (2) increased generalizability, (3) enhanced recruitment and retention, and (4) potential cost savings. The authors conclude that the transition from research to service still requires

rigorous evaluation. 1 table, 38 references. (HE9700612)

005

**Health and Rehabilitation Manpower Strategy: New Careers and the Role of the Indigenous Paraprofessional.**

**Form:** Journal article.

**Author:** Smith, R.T.

**Source:** Social Science and Medicine. 7(4):281-290, April 1973.

**Abstract:** A strategy to alleviate the acute health manpower shortage in the United States involves increasing the supply of allied and auxiliary health personnel and developing new types of paraprofessional roles that serve to supplement the health professionals. One of the innovative health manpower approaches involves employing persons of low-income or undereducation in human services fields, with provisions for job upgrading through work-study programs. Essential components of this new careers model include (1) full-time employment; (2) on-the-job skill training; (3) remedial and postsecondary educational training with release time to engage in this activity; (4) career ladder advancement through progressive job opportunities requiring higher levels of skill and greater responsibility; (5) supportive service during training (e.g., child care, welfare, and medical assistance); and (6) agency job commitment and placement on completion of training. The attainment of job skills and knowledge, combined with formal educational achievement, provides a new pathway to paraprofessional status in the allied health manpower sector. The worker can pursue a dual track of job advancement, through work and education, somewhat akin to the system used in the military and private industry. The new careers model is part of a more general change strategy in the development and use of



indigenous paraprofessionals in the health care and rehabilitation system. This strategy defines the role of the new paraprofessional in terms of four broadly conceived functions: (1) bridging or linking, (2) client advocacy, (3) helper therapy, and (4) change agent. As a strategy for increasing the number of allied health workers and for providing the disadvantaged with career job opportunities, the new careers model has met with limited success, perhaps because of lack of program implementation rather than inherent defects of this model. Still unclear is the extent to which these programs are viable and functionally relevant to the long-range goal of providing comprehensive and continuous service to those in need in the community. 2 tables, 39 references. (HE9700305)

006

### Health Care and Community Action.

**Form:** Journal article.

**Author:** Donoso, G.

**Source:** WHO Chronicle. 32(3):102-105, March 1978.

**Abstract:** In most developing countries, the goal of health for all by the year 2000 will not be achieved unless effective, low-cost health care is put into practice and untapped manpower and other community resources are used. The greatest health gap in developing countries is among children under age 5 years and by extension their pregnant or nursing mothers. The World Health Organization (WHO) has identified the need to redirect resources from conventional disease-oriented curative programs to preventive community health programs designed to improve the health status of underserved people. Community participation and self-reliance are essential to primary health care. Community resources must be supplemented by essential supplies, technical supervision and training, and a system

for the referral of severe cases to higher health centers. Health programs should emphasize low-cost activities that have a proven effect on reducing sickness and death. Programs should rely on local people trained to carry out activities and to promote community organization for health. The community must accept the work and advice of the trained community health worker. Continuous training and supervision of community health workers are essential to improve their technical abilities and their standing in the community. WHO has established these priorities: (1) Preconceptual, prenatal, natal, and postnatal care; (2) family planning; (3) promotion of healthy growth through protecting children's nutritional status during the first 5 years of life; (4) treatment and prevention of infections in mothers and children; and (5) promotion of family self-reliance in health care through health education. WHO is collaborating with member states in (1) improving support from the central level by giving family health needs the highest place in health planning and in the administration and allocation of resources; (2) training teachers who will train community health workers and auxiliary personnel; (3) developing guidelines, curricula, and manuals adapted for the community level; (4) improving treatment and prevention of acute diarrheal diseases; (5) making available information and services for fertility regulation; (6) encouraging improved care during pregnancy and childbirth through the training of auxiliary and traditional midwives; (7) promoting improved nutrition as part of family health; (8) promoting health and nutrition education aimed at breaking the links between malnutrition, infection, and uncontrolled childbearing; and (9) promoting expanded programs of immunization. 4 references. (HE9700088)

007

**High-Risk Vulnerable Populations and Volunteers: A Model of Education and Service Collaboration.****Form:** Journal article.**Authors:** Hutchison, R.R.; Quartaro, E.G.**Source:** Journal of Community Health Nursing. 12(2):111-119, 1995.

**Abstract:** Health educators present a model of collaboration between education and service organizations for the preparation of volunteers, who caring for high-risk vulnerable populations, such as frail elderly persons, homeless persons, persons with chronic mental illness, and persons with acquired immunodeficiency syndrome (AIDS). Factors that contribute to successful collaboration include (1) the ethos of volunteerism; (2) the congruence of the missions of education and service institutions; (3) the maturity of the collaborating organizations; (4) structural similarities and differences; (5) accreditation and standard-setting requirements; (6) homogeneity of clients, caregivers, and faculty; and (7) ethical, social, and legal issues. Volunteers include elderly, student, professional, and retired people and people of all ethnic, racial, religious, and socioeconomic levels. Professionals need help to empower volunteers to meet the needs of high-risk vulnerable populations. The broader the missions of the educational institution and the service agency, the greater the likelihood that their purposes will encompass each other. Identification of common ground between the organizations is the foundation of collaboration. The presence of highly professional staff at every level of mature organizations lessens the lead times and the preparatory interactions needed by the personnel involved. Tolerance of the zone of discretion of each organization and an ability to negotiate the unanticipated

differences and grey areas will advance the goals of the collaboration. Structural similarities and differences of collaborating organizations that must be considered include size, time, space, degree of formality, and hierarchial versus collegial organizational models. The early determination of sources of potential conflicts and their management are key to sustaining accreditation standards while supporting experimentation. Awareness of the need for homogeneity of cultures, especially ethnicity, is crucial to the collaborative effort. The cultural context includes age, sex, socioeconomic status, sexual orientation, religion, and health attitudes and practices. Ethical and social issues in working with high-risk vulnerable populations include confidentiality and perceived threats of harm. Contracts with the collaborating organizations should be as explicit as possible to guarantee shared and mutual understanding of the roles, goals, outcomes, and means of assessment of program effectiveness; contracts also limit the risks to which the collaborators and their respective sites are exposed. 1 table, 16 references. (HE9700089)

008

**Lay Health Advisor Intervention Strategies: A Continuum From Natural Helping to Paraprofessional Helping.****Form:** Journal article.**Authors:** Eng, E.; Parker, E.; Harlan, C.**Source:** Health Education and Behavior. 24(4):413-417, August 1997.

**Abstract:** More public health professionals are exploring the strategy of working through lay health advisors (LHA's) to contact communities considered hard-to-reach and to establish meaningful linkages to the service delivery system. A lay health advisor is one who is indigenous to the community and acts as a link



between community members and the service delivery system. Whether called community health advisors, community health workers, health aides, natural helpers, navigators, paraprofessionals, peer educators, promotoras, or outreach workers, LHA's share three basic principles of public health practice: (1) the basic assumption that social networks through which community members offer and receive social support among one another is a natural resource available in most communities; (2) the role of the practitioner is to recruit, train, and support community members who can directly reach and offer social support to those in need; and (3) the role of the recruited and trained community members is to bridge the agencies' formal service delivery system and the communities' informal social support system. LHA intervention strategies range from informal to formal helping. At the formal end of the continuum is the paraprofessional LHA strategy, which involves individuals carrying out tasks that would normally be carried out by practitioners. At the other end of the continuum is the natural helping LHA strategy. Natural helpers are people with a reputation in the community for good judgment, sound advice, a caring ear, and discretion. These people often do not meet the qualifications set by an agency, although they help people in their social networks with needs that cannot be met by the health system and they negotiate with professionals for support from the health system. The natural helping of these LHA's provides a community-based system of care and social support that complements the more specialized functions of health professionals. 1 figure, 8 references. (HE9701115)

009

### **Problem-Based Strategies Promoting Community Transformation: Implications for the Community Health Worker Model.**

**Form:** Journal article.

**Authors:** Barnes, M.D.; Fairbanks, J.

**Source:** Family and Community Health. 20(1):54-65, April 1997.

**Abstract:** The problem-posing techniques described by Paulo Freire provide a model for community transformation with the potential for community health workers (CHW's) to act as key agents of change. Community members can best identify relevant health problems and develop realistic plans to address them. Problem-posing is a participatory process in which organized community groups and facilitators collaborate through dialogue, critical thought, problem identification, and grassroots solutions to promote community change. This approach shifts the locus of control from the experts to the participants or learners. The Freire problem-posing approach promotes the learner as a full participant and encourages consensus-building, sharing, and respect for others' values and opinions. It shares several characteristics with problem-based learning: (1) relevant issues and problems influence participation, (2) participants are both learners and teachers, (3) participants identify and solve problems, (4) participants learn through self-discovery, (5) the process is a cycle of reflection and action, and (6) community transformation is carried out by the community members themselves. CHW's are in a prime position to assist in problem-posing activities that lead to community empowerment and transformation. They have a clear understanding of community problems and resources and can reach underserved populations. To enable CHW's to function as partners in community empowerment efforts, CHW training curricula

should provide opportunities for CHW's to learn the subject matter and apply it to real situations through problem-based learning techniques. CHW's trained in these techniques would then be able to model problem-posing for groups in their communities. In addition, CHW's should be encouraged to facilitate problem-solving groups in their communities to resolve immediate community problems. 35 references. (HE9700781)

010

### **Relationship Between Community Health Workers, the Health Services, and the Community.**

**Form:** Journal article.

**Author:** Flahault, D.

**Source:** WHO Chronicle. 32(4):149-153, April 1978.

**Abstract:** The roles and responsibilities of community health workers (CHW's) in different parts of the world vary according to the size of the community. In a developed area CHW's can include the family doctor, pharmacist, dispensary nurse, midwife, or social worker; in a rural area of a developing country, CHW's can include the medical or veterinary assistant, auxiliary nurse, traditional birth attendant, or traditional healer. All CHW's provide primary health care. Many participate in developmental activities concerning the individual, community, and country. CHW's may be defined as modestly trained male or female health workers living within the community and working in liaison with the health services of the country. They may be full-or part-time and paid or volunteer workers. The village health committee in a developing country is a local organization that can link the village community and health services. The roles of such local community organizations include (1) identifying health

needs and priorities, (2) organizing community action, (3) designating responsible persons as CHW's, (4) providing support to the CHW's, (5) participating in evaluation of community health services, and (6) linking health actions with broader community goals. For their part, health services must (1) review and agree on actions taken by the community; (2) provide training for CHW's and their teachers; (3) supervise and continue the education of health workers; (4) provide support, including referral facilities; and (5) participate in evaluation. Communities and health services must work together to plan and implement CHW programs. In this way, both communities and health services will share the responsibility of ensuring the health of the community. 8 references. (HE9700087)





# The Community Health Advisor/Worker

## Applications and Methods

011

### **Alliances of Professionals and Paraprofessionals: Who Owns the Turf? (Editorial Response).**

**Form:** Journal article.

**Authors:** Reim, G.; Osborne, O.

**Source:** Hospital and Community Psychiatry. 26(11):759-760, November 1975.

**Abstract:** This is an editorial response to an article by Dr. Oliver Osborne entitled "Issues in Achieving Effective Professional Alliances" and a rebuttal by Dr. Osbourne. The author states that while Dr. Osborne admits the important role of paraprofessionals, he views their role to be somewhat in contention with standard health professionals. The author disagrees with Dr. Osborne's apparent claim that paraprofessionals are often incompetent, and states that even current licensing requirements in many health fields do not guarantee competency. He suggests that paraprofessional workers should not be viewed as in competition with professionals, and therefore should not be pushed into getting the same academic degrees. In addition, the author suggests paraprofessionals that should be paid more than they are currently paid. In his response, Dr. Osbourne points out that his paper was not originally meant as a research paper, but rather as a speech discussing the issues that hinder or could potentially hinder interprofessional alliances. Dr. Osborne voices his disagreement with the author's view that professionals should be willing to share their turf with paraprofessionals. He notes that the type of training a paraprofessional has received and experience of working in the field are just as important as a degree or certificate.

Paraprofessionals, Dr. Osborne states, will never agree to pursue a different set of credentials than that currently sought by professionals. (HE9700328)

012

### **Bringing Providers to the People: Alaska and a Florida County Blaze New Trails in Non-Physician Care Delivery.**

**Form:** Journal article.

**Author:** Sherer, J.L.

**Source:** Hospitals and Health Networks. 68(3):56, 58, 60, February 5, 1994.

**Abstract:** A health professional describes Alaska's Community Health Aide Program, which trains village residents to deliver emergency and primary preventive care to villagers who live hundreds of miles from the nearest hospital and physician. Volunteers used by the federal government to dispense medications during the tuberculosis epidemic in the 1950's eventually became known as community health aides (CHA's). Today, more than 400 CHA's, village residents who are selected by members of the community, provide health care to 45,000 people in Alaska's 171 villages. CHA's must have at least a sixth-grade reading level and knowledge of math. They participate in a 4-month session of classroom instruction and skills practice to learn basic history taking, physical assessment, and diagnostic skills. Before they begin practicing independently, they must complete 2 to 3 years of clinical observation by physicians. The state contributes \$2 million annually in training funds to the CHA project, but most funding comes from the Indian Health Service, a federal agency that delivers and oversees care

through Alaska's 12 Native Health Corporations. The CHA program has brought about a dramatic improvement in the Alaskan population's health status over the past decade, prompting marked declines in cases of hepatitis B, gonorrhea, and rheumatic fever. Health officials in Pinellas County, Florida, have proposed that the county follow Alaska's lead by expanding their own emergency medical personnel and allowing paramedics to deliver primary health services to the indigent. Officials have been unable to implement the program, however, because of practice and licensing laws and other barriers. (HE9700078)

013

### **Changes in Empowerment: Effects of Participation in a Lay Health Promotion Program.**

**Form:** Journal article.

**Authors:** Booker, V.K.; Robinson, J.G.; Kay, B.J.; Najera, L.G.; Stewart, G.

**Source:** Health Education and Behavior. 24(4):452-464, August 1997.

**Abstract:** The Camp Health Aide Program is a lay health promotion program for migrant and seasonal farmworkers designed to increase access to health care while aiding in leadership development and empowerment of individual farmworkers through training and experience as lay health promoters. Since its inception in 1985, more than 250 migrant farmworkers were trained as camp health aides to provide health education, first aid, referrals for health and social services, and translation services for their friends, neighbors, and coworkers. In 1992, the authors examined how participation in the program affects the lay health promoters. The authors conducted in-depth interviews with a group of community health advisors (CHA's) at three project sites in Arizona, Florida, and New Jersey at three points in time: (1) shortly after

they entered the program but before training began; (2) 4 to 8 months later; and (3) at the end of the second harvest season, approximately 16 months after the program began. The questionnaire included questions concerning (1) life experiences, (2) experiences as a farmworker, (3) likes and dislikes of farmwork, (4) goals, (5) health-related problems of farmworkers, (6) actions they would take in case of an accident or illness, (7) what people could do to stay healthy and the likelihood of carrying out these behaviors, and (8) expectations about being a CHA. The researchers found that most of the advisors exhibited some increase in personal empowerment during the study period. Findings indicate that there may be additional benefits to lay health promotion programs beyond increasing access to health care and providing culturally appropriate health education to underserved communities. Changes in the personal empowerment of participants, while difficult to measure precisely, are important program benefits. 13 references. (HE9701117)

014

### **Community-Based Primary Health Care Program for Integration of Research, Practice, and Education.**

**Form:** Book chapter.

**Authors:** McElmurry, B.J.; Swider, S.M.; Norr, K.

**Source:** In: Curriculum Revolution: Community Building and Activism. National League for Nursing. New York, NY, National League for Nursing Press, pp. 77-90, 1991.

**Abstract:** This chapter describes the Primary Health Care in Urban Communities demonstration project in Chicago, Illinois. The program focuses on the development of a university setting that responds to the primary



health care concerns of an urban population and that uses the expertise of the project staff in women's health research and education to better their understanding of women's health problems and their resolution. Community residents were recruited to become community health workers, working in teams with community health nurses. The nurse/advocate teams conduct community assessments and work in community locations, including a clinic, church basement, and school. The authors note that developing a community-based nursing practice that integrates the traditional university functions of research, service, and education is consistent with the World Health Organization's 1984 resolution on the role of universities in contributing to human development and social justice. (HE9600950)

015

### **Community Empowerment in Rural Health Care.**

**Form:** Journal article.

**Authors:** May, K.M.; Mendelson, C.; Ferketich, S.

**Source:** Public Health Nursing. 12(1):25-30, February 1995.

**Abstract:** Researchers designed a community health nursing project with three interventions: community empowerment, personalized preventive nursing, and organized indigenous caregiving. The article discusses the intervention that involved community empowerment to address the health needs of small, rural, underserved, primarily Hispanic American communities in Arizona. The community-empowerment intervention involved the use of community health nurses and lay health workers to identify health priorities and plan and implement health programs. During the project's early stages, staff and community members sponsored a

health fair at a major community fiesta, where they provided health education, offered screening tests, and collected health information from the 60 attendees. After establishing relationships with community members and informing them about the project, the community health nurse and lay health workers planned community empowerment strategies, including a second health fair, in response to concerns about heart disease, diabetes, risk factor identification, and low-cost blood screening. Three hundred people attended the second health fair. Both fairs provided handouts and discussion offered and occult blood tests and cardiac risk profiles. The second health fair also offered immunizations and appointments for low-cost mammography screening. Although attendance at the first health fair was lower than hoped, feedback indicated participants' satisfaction. The community health nurse and the lay health workers based their evaluation of the second fair on attendance, community involvement, and degree of satisfaction reported by participants. The fair exceeded expectations of attendance and level of community involvement. Informal feedback indicated satisfaction with the services provided. Researchers could not evaluate the immediate effect of the fair on community health and empowerment. 26 references. (HE9500589)



016

### **Community Facilitator Implementation Manual.**

**Form:** Manual.

**Corporate Author:** University of Southern Mississippi, Center for Community Health.

**Source:** Hattiesburg, MS, University of Southern Mississippi, Center for Community Health, Community Health Advisor Network, 56 p., 1996.

**Abstract:** The Community Facilitator Implementation Manual provides step-by-step instructions on how to implement the Freedom From Hunger/Community Health Advisor Network (CHAN), located in Hattiesburg, Mississippi. The manual includes information about (1) entering a community and building broad-based support for an initiative, (2) identifying community members who are designated by their peers as natural helpers, (3) recruiting natural helpers to participate in a community development project, (4) building consensus about community problems that need to be addressed, (5) training volunteers to better address community problems, (6) supporting volunteer efforts, and (7) building linkages between volunteers and service-providing agencies in the community. The manual contains eight chapters. (HE9700746)

017

### **Community Health Advisor Program: Training Curriculum.**

**Form:** Teaching guide.

**Corporate Author:** University of Southern Mississippi, Center for Community Health.

**Source:** Hattiesburg, MS, University of Southern Mississippi, Center for Community Health, Community Health Advisor Network, 238 p., n.d.

**Abstract:** This curriculum is designed to train members of the community to be Community Health Advisors who will work to improve individual and community health and nutrition by linking neighbors, friends, and families to local service providers. The training program has 10 sessions; sessions 2 through 9 each have two parts, one on health and nutrition and one on community leadership skills. The health and nutrition topics address health promotion, chronic disease, good nutrition, maternal health, child health, communicable disease, mental health and substance abuse, and community health and safety services. Specific training procedures, participant worksheets, and evaluation activities are included for the session on health promotion and for all leadership skills sessions. Session 1 helps participants explore their community's unique situation, the challenges facing the community, and possible solutions. Session 2 discusses the role of the community health advisor in giving advice, providing assistance, and mobilizing others to action. Sessions 3 and 4 describe the basic discussion method, a tool for effective conversation with individuals and groups. Sessions 5, 6, and 7 teach participants how to create and lead workshops that will help diverse community groups identify problems and generate solutions. Session 8 addresses skills for facilitating broad community participation. Sessions 9 and 10 teach participants how to

identify priorities for action and develop plans to implement those priorities. (HE9700747)

018

**Community Health Advocacy: Primary Health Care Nurse-Advocate Teams in Urban Communities.**

**Form:** Book chapter.

**Authors:** McElmurry, B.J.; Swider, S.M.; Bless, C.; Murphy, D.; Montgomery, A.; Norr, K.; Irvin, Y.; Gantes, M.; Fisher, M.

**Source:** In: Perspectives in Nursing 1989-1991. National League for Nursing. New York, NY, National League for Nursing, pp. 117-131, 1990.

**Abstract:** This chapter describes the Community Health Advocacy Project, a team of community health advocates and nurses that collaborates in defining, developing, and implementing strategies responsive to the concerns and essential health needs of community residents. The project has been implemented in two low-income communities in Chicago, Illinois, one with primarily African American residents and the other with primarily Hispanic residents. Women from each community were trained as health advocates, which prepared them to work with public health nurses in their communities. During the first year of the project, the nurse-advocate teams identified health problems in their community, talked with community residents about health concerns, and assessed the available health and social services. As the nurse-advocate teams worked out of the community sites and met once a week to share their experiences, project staff gathered data on health status indicators for each community. The advocates and project staff developed an interview guide for a health survey. By the end of the first year, the advocates had formulated a list of priority health concerns in their community, based on

their work with residents. The list included parental stress, substance abuse, adolescent pregnancy, lack of quality medical services, nutrition, mental health, crime, and domestic violence. In addition to assessment activities in the project's first year, the nurse-advocate teams performed some individual advocacy functions for people in need of referral for health and social problems. In the second year, the team increased these services and developed plans to address the most pressing community health needs identified in the assessment process. The nurse-advocate teams work on activities such as first aid classes for children, well-child care, parental support groups, hypertension and breast cancer screening, acquired immunodeficiency syndrome education, and nutrition education. Evaluation of the project involves documenting activities and collecting qualitative data. (HE9600951)

019

**Community Health Aide Program: Health Care for Rural Alaska Natives by Rural Alaska Natives.**

**Form:** Journal article.

**Author:** Caldera, D.L.

**Source:** Arctic Medical Research. (Supplement):166-169, 1991.

**Abstract:** The Community Health Aide Program (CHAP) serves approximately 45,000 people living in 171 Native villages located up to 1,300 miles from the nearest traditional medical facility. The health status of rural Alaskan Natives is related to poverty, rapid social change, harsh climate and terrain, and the isolation of the communities where they live. The CHAP program grew out of Congressional recognition of the poor overall health of the Natives and the need to increase their health services. Momentum for the formal training of village health workers increased between 1940



and 1960. In 1968, Congress appropriated funds for training and salaries for 185 community health aides (CHA's) to work in 157 villages. The Alaska Native Claims Settlement Act of 1971 created nonprofit corporations to administer health, education, and social welfare programs for the Natives; these corporations are now known as regional provider agencies (RPA's). A manual, *Guidelines for Primary Health Care in Rural Alaska 1976*, was developed for statewide use outlining assessment and treatment guidelines for the village health worker. CHA's are Native health workers selected from and by the communities in which they live and work to provide primary health care in the villages. In addition to patient care responsibilities, CHA's manage the clinic and maintain clinic records, supplies, and pharmacy. CHA's are the first point of contact to the Native health care system for most rural Alaska Natives. Although CHA encounters tend to be acute care oriented, CHA's are also involved in the provision of prenatal and well child care. In the development of an appropriate patient care plan, the CHA relies on the physicians and midlevel practitioners working in referral hospitals. Consulting physicians act as medical supervisors for the CHA's, and the RPA supervisors support the CHA's through their daily challenges. Basic training consists of three training sessions, lasting 4, 3, and 3 weeks respectively, followed by a 2-week preceptorship. The Federal Tort Claims Act provides liability coverage for federal employees and thus for CHA's. CHA's have become an indispensable component of health care for Alaska Natives. Indexes of health status among Alaska Natives, such as infant mortality, life expectancy, number of persons hospitalized, and length of hospitalization have improved since the CHA training and employment program began. 13 references. (HE9700302)

020

### **Community Health Worker Programs: A Leadership Brief on Community Preventive Health.**

**Form:** Report.

**Corporate Author:** Georgetown University Law Center, Harrison Institute for Public Law and Codman Square Health Center, Civic Health Institute.

**Source:** Washington, DC, Georgetown University Law Center, Harrison Institute for Public Law. Dorchester, MA, Codman Square Health Center, Civic Health Institute, 24 p., February 1997.

**Abstract:** This report discusses the design and effect of community health worker (CHW) programs across the country. The first section discusses the role of prevention services in the health care system and the benefits of preventive health approaches. The second section describes the role of the CHW and explains how CHW's can increase access to health care for medically underserved populations, improve quality of life and health care, provide cost savings to health systems and taxpayers, and promote positive social outcomes for both individuals and the community. The third section addresses the variables around which CHW programs are designed: the mission or philosophy, focus, target population, CHW roles and job titles, method (e.g., home visit, health classes, mentoring, or advocacy), and host agency. The fourth section profiles the key program variables of four CHW programs: (1) Community Outreach Intervention Projects, (2) the Latino Health Access Project, (3) the Community Health Partnership, and (4) the Community Health Representative Program, which is provided through the Indian Health Service. The fifth section presents data that illustrate the effectiveness of several CHW

programs. The sixth section outlines various types of public and private support for CHW programs, including state policies and funding, recommendations from the National Community Health Advisor Study, and linkages with managed care organizations. The seventh section presents a policy agenda for CHW programs and recommends steps that states, foundations, and CHW's can take to support the integration of CHW programs into local health care systems. The final section describes resources available to CHW programs, including training guides and curricula, information sources, CHW and program networks, and state associations and networks. (HE9700749)

021

**Community Health Workers: The Interface Between Communities and Health Care Systems.**

**Form:** Journal article.

**Author:** Bryant, J.H.

**Source:** WHO Chronicle. 32(4):144-148, April 1978.

**Abstract:** The community health worker (CHW) approach can reach rural and urban low-income residents in ways that mobilize their abilities and stimulate their interest in improved health as part of a movement towards a better future. CHW's can provide a link between the resources of the community and those of the health care system. Challenges confronting CHW's include (1) reconciling the conflict of allegiance to the community on one hand and the health system on the other and (2) balancing individually oriented, clinically directed health care with group-related, epidemiologically oriented functions. To establish community-oriented programs, CHW's need technical skills that enable them to lead their communities in first, assessing

problems and needs, and then planning, implementing, and evaluating the programs. Selection and training of CHW's influence patterns of allegiance. Those who select, train, supervise, and pay CHW's will have a strong influence on the direction and quality of their accountability. An important question is whether communities should retain control over all aspects of CHW's or whether centralized agencies of government should extend their system to communities. The choice probably should be both, allowing for solutions that encompass community control and the equitable distribution of services. The most important principle is that a CHW program must be community-based and designed to meet the needs of the people instead of people serving the systems. The article summarizes discussions at a symposium on CHW's, organized by the African Medical and Research Foundation International at Airlie House, Virginia, in October 1977. 1 table. (HE9700086)

022

**Community Health Workers: Who They Are and What They Do.**

**Form:** Journal article.

**Authors:** Love, M.B.; Gardner, K.; Legion, V.

**Source:** Health Education and Behavior. 24(4):510-522, August 1997.

**Abstract:** The authors present the results of a mail survey of health care providers in eight northern California counties. The survey was designed to gather descriptive data on the roles, background, and working conditions of community health workers (CHW's). The population of health care service providers in the eight counties was stratified by type of health care organization. A preliminary screening determined if organizations employed or planned to employ CHW's. Organizations



that either currently employed at least one CHW or intended to hire at least one CHW during the next 3 years were eligible for the survey. A total of 504 CHW's were working in 62 agencies; of these, 65 percent were employed full time and 35 percent part time. County health departments were the biggest employers of CHW's (63 percent), followed by community-based organizations and clinics (35 percent). Fifty-five percent of the CHW's were paid from ongoing hard-money funds; 42 percent were paid through grants of 3 years or less. Most CHW's were women (66 percent) of color (77 percent) with a high school degree or less (58 percent). The largest concentration of CHW's work in the area of HIV/AIDS and other sexually transmitted diseases (17 percent), followed by maternal child health/perinatal care (16 percent), alcohol and drug abuse (11 percent), and primary care (10 percent). Skills that respondents reported as most important to community health work were multicultural competence, community outreach, and communication and conflict resolution skills. Respondents reported that the skills that they had the most difficulty finding when hiring CHW's were group facilitation skills, self-management (job readiness), and reporting and documentation skills. Barriers to wider employment of CHW's included (1) budget constraints, (2) lack of acceptance by other professionals, (3) difficulty in supervising employees with uneven preparation, (4) lack of acceptance of the CHW field, and (5) lack of acceptance by clients. 6 tables, 38 references. (HE9701120)

023

### **Community Representatives: New Directions in Education and Outreach.**

**Form:** Manual.

**Corporate Author:** San Diego County Department of Health Services, Division of Public Health Education.

**Source:** San Diego, CA, San Diego County Department of Health Services, Division of Public Health Education, Tobacco Control Resource Center, 78 p., 1995.

**Abstract:** This manual offers guidance for program coordinators who are interested in using community representatives in community health education or outreach programs. Community representatives can be lay people or established professionals who live or work in the targeted community. They are usually of the same ethnic and cultural background as their clients and serve as a bridge to available services and resources in a community. The community representative model can be incorporated into existing programs or used as a strategy when developing new programs or projects. The first section of the manual, Keys for Program Coordinators, outlines the functions of the program coordinator in relation to community representatives. It addresses recruiting, training, and overseeing community representatives and includes information on the special needs of youths who serve as community representatives. The second section, Directions and Ideas to Share with Community Representatives, suggests that program coordinators (1) teach the community representatives how to understand the client, (2) learn to identify community resources and notify clients of these resources, (3) make a polished presentation to clients, and (4) use incentives. The third section, Strategies for Education and Outreach, describes how to schedule and conduct presentations and

outreach through local agencies, religious organizations, schools, and apartment complexes, and at community health fairs. Appendixes for each section contain sample fliers, forms, attendance rosters, telephone scripts, presentation outlines, and pre- and posttest measurements. (HE9700733)

024

### **Evaluating Training Programs for Paraprofessionals and Nonprofessionals.**

**Form:** Journal article.

**Authors:** D'Augelli, A.R.; Danish, S.J.

**Source:** Journal of Counseling Psychology. 23(3):247-253, 1976.

**Abstract:** The authors discuss three major areas relating to training programs for paraprofessional and nonprofessional human service workers and detail a potential research strategy for evaluation of each area. The first strategy concerns assessment of the relative importance of selection versus training of paraprofessional helpers. It is assumed that careful selection of individuals with certain qualities will result in effective helpers. A design is offered to determine the differential usefulness of selection and training. The design has four operational stages representing points in the candidate's journey through the selection and training process: selection, training, assessment, and evaluation. The second strategy focuses on identifying critical factors that produce effective paraprofessional training. It assesses factors that contribute to learning in terms of their salience in a given training program. The third strategy entails an evaluation of both the learning occurring through the training and the effect of systematically trained paraprofessional helpers on their target group clients. A dual approach is recommended in which several training groups

representing different training approaches are contrasted with control groups and then the effect of trained helpers is examined. Multiple measures, objective and self-report, are included in the evaluation of the program. The strategies outlined are intended to represent an initial approach to an empirical base for training paraprofessional workers. The authors note that paraprofessionals and nonprofessionals are likely to be essential in the delivery of mental health services in the future. 3 figures, 34 references. (HE9700494)

025

### **Family Dynamics for Paraprofessional Workers.**

**Form:** Journal article.

**Author:** Ogren, E.H.

**Source:** Family Coordinator. 20(1):11-16, January 1971.

**Abstract:** A course in family dynamics was developed to help paraprofessional family health workers in an urban neighborhood health center become an integral part of a comprehensive health care team. The family health workers served as clinic assistants and case finders, recorded family data, encouraged families to use the services, and educated families regarding good physical and mental health practices. The workers were generally 21 to 50 years old, most were female, and most had completed high school. The training program focused on mechanical and communication skills, knowledge necessary for task fulfillment, and the development of positive attitudes. The theory of family interaction was one of the mental health concepts taught, along with physiological and medical information. The goals of the course included (1) increasing understanding of some of the social aspects of human behavior, (2) correcting stereotypes, (3) developing a positive



approach to problem solving, and (4) understanding the relationship between the community and larger society and how the family can be helped to become a healthier unit. Lectures on theoretical material followed an outline form to facilitate note-taking by the trainees. Numerous vignettes and examples were given to initiate class discussion and emphasize the relevance of the material. A more complete course was developed for two later training programs lasting 4 months and 6 months and involving nearly 50 trainees. Indications through observation are that goals were met, although no formal assessment was conducted. 10 references. (HE9700735)

026

### **Family Health Worker Revisited: A Five-Year Follow-Up.**

**Form:** Journal article.

**Authors:** Torrey, E.F.; Smith, D.; Wise, H.

**Source:** American Journal of Public Health. 63(1):71-74, January 1973.

**Abstract:** The authors assess a group of family health workers 5 years after they were trained at the Dr. Martin Luther King, Jr. Health Center in the Bronx, New York. The population served by this health center is approximately half African American and half Hispanic American. The family health workers were all recruited from this population, had a variety of family and educational backgrounds, and ranged in age from 25 to 53 years (average age was 38 years). They learned aspects of nursing, health education, and social advocacy. Of the 72 family health visitors trained, 50 had worked steadily at the center. One became the Deputy Director of the center, nine went on for further training, and six resigned. All who were current employed were working as part of a primary care health team consisting of an internist, a pediatrician, two nurse practitioners

and six family health workers. The daily tasks carried out by the family health workers reflect the problems of some of the families in the area. The family health workers encountered problems that included (1) self-esteem; (2) the difficulty of changing roles for the family health worker, supervising nurse, and consulting physician; (3) lack of upward job mobility; (4) lack of lateral job mobility; (5) paternalism; (6) lack of project evaluation; and (7) questionable conceptual validity for the role of nursing-health educator-social advocacy. 7 references. (HE9700309)

027

### **Helping Beliefs Inventory as a Predictor of Volunteer Counselor Training Outcome.**

**Form:** Journal article.

**Authors:** Kelly, N.J.; McLennan, J.P.; Gotts, G.H.

**Source:** Psychological Reports. 66 (3, Part 1): 970, June 1990.

**Abstract:** The Helping Beliefs Inventory is a self-report measure of an individual's espoused beliefs about the helpfulness of various counseling responses that can be used to predict success as a volunteer. Relatively higher scores indicate the belief that it is often helpful to distract clients from their feelings of distress, divert them from their problem situations, and tell them what to do. The inventory is both internally consistent and stable; scores are related to authoritarianism, low psychological-mindedness, and lack of flexibility. A pretest was administered to 51 volunteer counselor-trainees with the Personal Emergency Service, a large, metropolitan, voluntary, telephone crisis-counseling agency sponsored by the Health Department of Victoria, Australia. After completing the inventory, the volunteers (41 females and 10 males) began the agency's standard 30-hour, small-group-based telephone

counseling skills training program. Instructors were not informed of trainees' scores. By the end of the training program, 26 applicants (20 females and 6 males) either had chosen to quit or had been asked to leave by the instructors. The mean pretraining scores of discontinuing trainees was significantly higher than those of the 25 applicants who completed the training. Two judges evaluated the posttraining counseling skill level of those 25 trainees who completed the program using the agency's structured Trainee Evaluation Form. Pretraining inventory scores were significantly correlated with posttraining counseling skills ratings and with posttraining scores. The researchers concluded that these findings confirm previous indications that the Helping Beliefs Inventory taps personal characteristics related to success in the training of basic counseling skills. 1 reference. (HE9700337)

028

**How-To Guide of CURE/Heart, Body and Soul, Inc.: A People-Work in Progress.**

**Form:** Manual.

**Author:** Cameron, L.

**Source:** Baltimore, MD, CURE/Heart, Body and Soul, Inc., 19 p., September 1996.

**Abstract:** The How-to Guide of CURE/Heart, Body and Soul, Inc.: A People-Work in Progress presents the organization's model for planning and implementing community health promotion programs. The essential characteristics of this model include (1) community-based leadership and ownership of specific programs, (2) training and use of indigenous community health workers, (3) interdisciplinary community practice and training opportunities, (4) built-in evaluation, and (5) broad community development and long-term maintenance of effective strategies. Section 1, Breaking Ground, describes

strategies for successful partnership building with special emphasis on how to get the church involved. Section 2, Pouring the Foundation: Structuring the Organization, suggests how to formalize the organization especially regarding issues such as nonprofit status, fiscal management, and administration. Section 3, Putting Up the Frames, describes the prevention program model, including the purpose of the program, the services offered, and the neighborhood health worker program. Section 4, Tending to Furnishings, explains the six steps used to develop programs. Section 5, Working with Raw Materials, describes goals and a variety of approaches to community health education. Section 6, Making It Last, explains how to maintain a program. (HE9700465)

029

**Improvement of Community Health Services Through the Support of Indigenous Nonprofessionals.**

**Form:** Journal article.

**Author:** Murphy, M.A.

**Source:** Journal of the New York State Nurses Association. 3(2):29-33, October 1972.

**Abstract:** Based on experiences with an urban community outreach program, a nurse (1) demonstrates the reasons for the emergence of the indigenous nonprofessional in a specific health care setting, (2) discusses ways in which the nonprofessional has been effective, (3) exposes problems inherent to the professional-nonprofessional relationship, and (4) examines means by which the relationship conflict can be resolved. The outreach center was a direct result of an urban, low-income, high-crime community's demands for a health component that they could call their own. The community was composed of five subgroups that included (1) Irish-Catholics living in apartments and housing projects, (2) blacks living in housing



projects, (3) Hispanics living in housing projects and isolated by language and cultural barriers, (4) university students living in more desirable spaces, and (5) people with social and economic mobility living in high-rise, high-rent apartments. Community representatives and a new prepayment group practice health plan initiated a contract program that used community coordinators to canvass the community for prospective enrollees for the new prepayment group practice health plan. The coordinators served as the emissaries between the health care system and the people. The coordinators interpreted the plan to residents, assisted enrollees in completing a medical questionnaire, acquainted them with the appointment system, made arrangements for transportation, and accompanied some members on their visits to the doctor or laboratory. Increased membership in the health plan expanded the role expectations and responsibilities of the coordinators, advocates, interpreters, counselors, and crisis interveners. At the outreach center, coordinators and their case work supervisor defined the coordinator's role, which affected the kinds of services and the personnel at the outreach center. 10 references. (HE9700335)

030

### **It's a 24-Hour Thing, a Living-for-Each-Other Concept: Identity, Networks, and Community in an Urban Village Health Worker Project.**

**Form:** Journal article.

**Authors:** Schulz, A.J.; Israel, B.A.; Becker, A.B.; Hollis, R.M.

**Source:** Health Education and Behavior. 24(4):465-480, August 1997.

**Abstract:** Understanding the experience and perceptions of community members involved in lay health advisor (LHA) programs is essential

for health educators who design, implement, and evaluate such programs. The authors examine these factors from the perspective of a small group of LHA's, called village health workers, working in a large urban community in Detroit, Michigan. The Village Health Worker Project is an intervention based on an ecological approach designed to create change at the individual, organizational, and community levels. Using data from focus groups, in-depth interviews, document review, and participant observations, the authors explore (1) village health workers' understanding and experience of their work across these levels and (2) the interface between lay health work and a sense of self in relation to community. A focus group was structured around descriptive and reflective questions. The village health workers described themselves as community-oriented people. They said they believed it was essential for village health workers to like people, to be committed to community work and readily available, and to have a personal or spiritual foundation that supported service and action in the community. The workers described themselves as providing affective, instrumental, and informational support. They said they brought information about many health-related topics and resources within the community to community members through their day-to-day activities and worked for change in their communities. Many workers spoke of the knowledge they acquired about health concerns and community resources, and the skills that enabled them to convey information more effectively to friends and neighbors. They said they were actively encouraged by the opportunities the work provides, such as the chance for personal change and growth, participation in collective activities, greater access to resources, employment, and personal satisfaction. This study has implications for (1) designing programs that build on LHA expertise and

knowledge of their communities, (2) structuring the relationship of LHA programs to community organizations and institutions, and (3) supporting LHA activities toward change at multiple levels in their communities.

47 references. (HE9701118)

031

### **Latino Health Advocacy Program: A Collaborative Lay Health Advisor Approach.**

**Form:** Journal article.

**Authors:** Baker, E.A.; Bouldin, N.; Durham, M.; Lowell, M.E.; Gonzalez, M.; Jodaitis, N.; Cruz, L.N.; Torres, I.; Torres, M.; Adams, S.T.

**Source:** Health Education and Behavior.

24(4):495-509, August 1997.

**Abstract:** The authors discuss the Latino Health Advocacy Program in Winchester, Massachusetts, and describe program development, the methodology used to monitor and evaluate the pilot project, and some initial results of program activities. The Latino Health Advocacy Program is a collaborative, culturally appropriate, holistic, and ecological lay health advisor pilot project intended to improve access to and use of health and human services by the Latino community through a culturally sensitive model of prevention and empowerment. The program design group initially had 12 members, with a core group of 7 (5 Latinos and 2 non-Hispanic whites) who worked throughout the pilot period. The program design group decided to increase knowledge and awareness of community resources and address the barriers to using health and human services. The group worked with community health and human service agencies and also developed a Spanish health resource library containing health and human service materials that were used in working one-on-one with clients and in conducting community outreach activities (e.g.,

mesas informativas de salud, or health information tables). The program group conducted program activities in one neighborhood with a large Latino population and in several health and human service agencies accessible to the community. Evaluation focused primarily on formative evaluation activities. These included community outreach forms, intake forms, and written and audiotaped progress notes. Data suggest that clients were working with the advocates to access services and resources in the community and that Latino health advocates were able to address underlying causes of the problems rather than just symptoms. In addition, the program staff used the mesas informativas de salud to provide health information as well as information about health and human service agencies. Moreover, other community health practitioners could use the information in their work. The authors suggest that lay health advisor models that are culturally appropriate, holistic, ecological, and based on local needs can have a positive effect on a community. 15 references. (HE9701119)

032

### **Lay Home Visiting Programs: Strengths, Tensions and Challenges.**

**Form:** Journal article.

**Authors:** Lerner, M.; Halpern, R.

**Source:** Zero to Three: Bulletin of National Center for Clinical Infant Programs. 8(1):1-7, September 1987.

**Abstract:** The authors discuss the strengths of the home visiting strategy that uses lay community workers and the tensions and implementation challenges that make it difficult for these programs to achieve maximum benefits. Home visiting typically combines core activities such as information sharing, modeling, demonstration, emotional support,



joint problem solving, and service brokerage and assistance in meeting pressing needs. Home visits represent a way to reach out to young families by offering sustained contact and placing the helping interaction in a less threatening environment than that found in most agencies. Lay workers can find eligible families by using their networks of personal contacts and knowledge of local activity patterns and they tend to be accepted by families more quickly than professionals might be accepted. Implementation challenges related to using lay home visitors include (1) articulating realistic roles for lay workers, (2) discovering skills and personal qualities in home visitors, (3) establishing a training system that builds on strengths and allows for the introduction of specialized knowledge, and (4) providing a supervisor who will nurture and monitor the continued development of the lay workers. Tensions confronting lay workers include (1) defining a new social role that is half-friend and half-intervenor, (2) juggling conflicting interpersonal purposes and styles demanded by the role, (3) moving back and forth between two cultures, and (4) building on experiences acquired through home visiting work in order to achieve personal goals in the wider society. 21 references. (HE9700495)

033

### Leadership for Primary Health Care.

**Form:** Journal article.

**Authors:** McElmurry, B.J.; Tyska, C.;

Gugenheim, A.M.; Misner, S.; Poslusny, S.

**Source:** Nursing and Health Care Perspectives on Community. 16(4):229-233, June 1995.

**Abstract:** In this article the authors describe the Leadership for Primary Health Care project, a collaborative effort of the Colleges of Nursing and Medicine at the University of Illinois at Chicago, that involved the development of a

partnership between the university and the communities in which faculty members and students participated. The project was designed to create a leadership academy of primary health care professionals and community advocates who understood the principles of primary health care and could apply and spread the philosophy, concepts, and strategies of community participation in their practice and educational and research activities. Academy members participated in an educational fellowship for an academic year, with weekly meetings. The educational component of the project consisted of five modules: primary health care, leadership development, community development, health care system organization, and information resources and data organization. Leadership fellows focused on developing eight skills: community identification and assessment, community assets identification, participatory planning, consensus building, community mobilization and organizing, negotiating, participation in public policy formulation, and critical thinking. Project staff said that they learned that the primary health care approach has the potential to address community health issues in more constructive ways than are typically used in conventional public health approaches. 1 figure, 3 tables, 2 references. (HE9600952)



034

**Models That Work: Compendium of Innovative Primary Health Care Programs for Underserved and Vulnerable Populations, 1996.**

**Form:** Directory.

**Corporate Author:** US Department of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Care.

**Source:** Bethesda, MD, US Department of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Health Care, 223 p., 1996.

**Abstract:** This directory profiles programs selected in 1996 by the Models That Work Campaign as examples of outstanding grassroots efforts to improve access to primary health care for underserved persons. The purpose of the campaign is to identify exemplary programs and encourage their replication in other communities. Applicants are judged on five criteria: community responsiveness, innovation, partnerships and collaboration between participating organizations, evidence of improved access to primary health care services and health-related outcomes, and program replication or sustainability. Many of the model programs use the community health advisor strategy. This compendium describes the 5 winning programs and the 10 special honorees selected in 1996. It also outlines applicant programs in 15 self-selected categories: business participation, city or county participation, dental health, farmworker health, health professions program participation, HIV/AIDS, the health of the homeless, hospital participation, low-budget programs, managed care, maternal and child health, religious organization participation, rural health, state coordination, and substance abuse prevention and treatment. Each

description includes the program name, address, telephone and fax numbers, contact person, and information about the services provided, populations served, linkages to other community organizations, and outcomes. The two appendixes contain an order form for additional information and a request form for presentations or workshops. (HE9700745)

035

**Models That Work: The 1995 Compendium of Innovative Primary Health Care Programs for Underserved and Vulnerable Populations.**

**Form:** Directory.

**Corporate Author:** US Department of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Health Care.

**Source:** Bethesda, MD, US Department of Health and Human Services, Public Health Service, Health Resources and Services Administration, Bureau of Primary Health Care, 177 p., 1995.

**Abstract:** The purpose of the Models That Work campaign was to disseminate information on successful primary care models and their strategies for serving vulnerable and underserved populations. It is hoped that the models may serve as guides for developing new partnerships between communities, academia, and public and private sector organizations. The models can also be used for developing managed care arrangements, maximizing resources through partnerships, assuring clinical quality improvement in health care services, establishing funding methodologies, and integrating underserved and vulnerable populations into mainstream systems of care. More than 30 of the model programs use the CHA strategy. The 1995 directory served as one of the mechanisms for disseminating this

information. The profiled models represent managed care organizations, insurers, social service agencies, public health agencies, and the religious community. The profiles include (1) the program name and contact, (2) services provided, (3) populations served, (4) linkages or collaborations, and (5) a summary of the program. (HE9700601)

036

### **National Community Health Advisor Study: Weaving the Future**

**Form:** Report and Executive Summary.

**Authors:** Rosenthal, E.L.; Wiggins, N.; Brownstein, J.N.; Meister, J.; Rael, R.; Guernsey de Zapien, J.; Ingram, M.; Borbon, A.; Johnson, S.; Koch, E.

**Source:** University of Arizona, 1998.

**Abstract:** This study examines the role of community health advisors (CHA's) in the United States. Data collection included qualitative and quantitative findings from site visits, interviews, focus groups, discussion groups, and a national survey of CHA's and CHA supervisors. The study explored four broad issues: (1) the development of CHA core role and job competency definitions and training curriculum; (2) evaluation strategies for CHA programs; (3) CHA career and field advancement; and (4) the integration of CHA's within the changing health care system, including managed care environments.

According to the authors, a common definition of CHA roles and competencies will better integrate CHA's into the health care continuum. To aid CHA programs, the study developed an evaluation framework that includes individual, family, and CHA documentation of changes; CHA program administration and implementation issues, such as the development of a strategic plan; documentation of changes at the community level; and interprogram and

national changes in the CHA program environment. Career advancement strategies for CHA's include the development of opportunities training and curriculum standards, development of program protocols in areas such as hiring and supervision, and development of interprogram and CHA networks and leadership development. CHA's must address new problems created by the changing health care system and the growth of managed care organizations. (HE9800121)

037

### **Nonobtrusive Interview Technique for Drug Abuse Program Follow-Up.**

**Form:** Journal article.

**Authors:** Sloan, J.L.; Lipscomb, W.R.

**Source:** Community Mental Health Journal. 11(4):368-370, Winter 1975.

**Abstract:** The authors describe a study of the effectiveness of a nonobtrusive interview technique for drug abuse program follow-up. Researchers interviewed 65 former clients in an outpatient drug abuse treatment program. The interview was designed to appear to a third party as a casual street-corner conversation. The researchers trained paraprofessional street workers who were known and trusted in the community as interviewers. Using role playing, the street workers then used a mnemonic device to guide the conversation over 46 items of more or less factual information. The interviewers recorded the information later from memory on a form. The number of items associated with each subscale was generally limited to seven to nine unrelated bits of information. A mnemonic device was used to cue recall of the 10 subscales: (1) housing, (2) relationship with others (not spouse), (3) legal status, (4) drug use, (5) educational status, (6) referral source, (7) relationship with spouse and sexual functioning, (8) health, (9) income, and (10)



plans for the future. Researchers attached Likert ratings to items of factual information to obtain a measure of the interviewer's estimate of the significance of each fact on the client's total functioning. The Likert rating procedure was standardized by having the interviewer rate videotaped interviews until their ratings agreed with a key at 80 percent identical responses for three consecutive interviews. An alpha coefficient reliability estimate of the Likert ratings on the 65 former clients was 0.923. Analysis of variance revealed no significant difference in the mean of total Likert points ascribed to clients over interviewers. A plot of the summed ratings revealed a bimodal pattern of ratings that indicates a useful discrimination among clients in terms of functioning. In the view of the interviewers, a person's plans for the future, current income, general health, and drug use pattern were more important to the interviewer's estimate of the client's general functioning than were other measures. In the authors' view, the most significant aspect of the study involves the utility of the data gathering technique. 2 figures, 3 references. (HE9700344)

038

### **Nurses' Role in Primary Health Care.**

**Form:** Journal article.

**Authors:** Bless, C.; Murphy, D.; Vinson, N.

**Source:** *Nursing and Health Care Perspectives on Community*. 16(2):70-76, March-April 1995.

**Abstract:** The University of Illinois College of Nursing launched the Primary Health Care in Urban Communities project to address the needs of two low-income urban communities, one mostly African American and the other largely Hispanic. Both communities were characterized by high crime rates and below-average health, social, and economic indicators.

The project staff teamed a public health nurse with four or five community residents to form a nurse-advocate team in each of the two communities. The teams worked with their communities' health and social service agencies, schools, churches, businesses, local government, families, friends, and neighbors to define and address health problems. Their services were available to all community residents. The primary strategy of the nurse-advocate teams was to provide education on issues identified by residents and to enhance residents' ability to improve their own health and that of their neighbors. The public health nurse used the community health assessment process to help the advocates and other community residents articulate their concerns and then helped them formulate a community health diagnosis. The assessment process was an early collaborative effort in which the advocates participated fully, helping to compile a directory of community health and social service resources. Nurse-advocate teams testified at community- and county-level meetings on health reform, assisted organizations that advocated on behalf of the health needs of immigrants and the homeless; and served on the development committees of community groups and organizations. Many of the teams' community organizing efforts focused on issues of violence. The roles of the advocates evolved over the course of the project, as did the individual leadership abilities and goals of the team. The authors recommend that the Public Health Nursing Sciences program equip nurses for the expanded roles required in community-based public health settings. By expanding to include community participation, nursing will promote the alternative models of health care needed to address the most difficult public health issues. 6 references. (HE9600953)



039

**Parents of Children With Rheumatic Disease as Peer Counselors.**

**Form:** Journal article.

**Authors:** DeNardo, B.A.; Stebulis, J.A.; Tucker, L.B.; Schaller, J.G.

**Source:** Arthritis Care and Research. 8(2): 120-125, June 1995.

**Abstract:** Between October 1990 and September 1992, seven pediatric rheumatology centers in New England implemented a parent consultant program to promote active family involvement in the health care process and provide peer support, education, and training to parents of children with rheumatic diseases. Parents of children with rheumatic diseases assessed the efficacy of medical treatments, identified areas of need that had not been addressed, performed physical and occupational therapy at home, located and coordinated health care, and performed other tasks. The program recruited parents of the children receiving care at the center to work part time in the clinics as parent consultants who are active members of the interdisciplinary team responsible for carrying out specific aspects of patient care. Parent consultant training included both didactic sessions on a multicenter level and clinical training within the individual clinic. A Parent Consultant Orientation Manual, developed by project staff, provided written practice guidelines. Annual questionnaires to parent consultants, clinical supervisors, and center directors evaluated satisfaction with the program. Any member of the health care team could refer a family to a parent consultant, who provided family education and technical assistance on specific nonmedical issues such as record keeping, health care financing, and educational issues and rights. Parents responding to an anonymous, mail-response questionnaire designed to evaluate program

effect indicated that their interaction with the parent consultant was very helpful (59 percent) or somewhat helpful (28 percent). The majority of respondents (98 percent) stated they would recommend that other parents meet with the parent consultant. Barriers to implementing the program on an ongoing basis included difficulty in recruiting and retaining parent consultants. 3 tables, 1 figure, 14 references. (HE9700100)

040

**Physician Assistant Training for Native Alaskan Community Health Aides: The MEDEX Northwest Experience.**

**Form:** Journal article.

**Authors:** Hummel, J.; Cortte, R.; Ballweg, R.; Larson, E.

**Source:** Alaska Medicine. 36(4):183-188, October-December 1994.

**Abstract:** Researchers assessed the outcome of training Native Alaskan health workers as physician assistants, specifically whether Native Alaskan graduates were working in settings that serve Alaska Natives. From 1980 through 1990, 16 Native Alaskan Community Health Aides and 21 non-Native Alaskan aides began physician assistant training at MEDEX Northwest at the University of Washington. The backgrounds, educational experiences, and deployment locations of Native and non-Native Alaskans accepted for training were compared using MEDEX Northwest student records. The 1991 graduate survey was used to compare differences in practice setting, specialty, and salary between Native and non-Native graduates working in Alaska in 1991. Results indicated that all of the non-Natives and 81 percent of the Natives completed the program. Of those completing the program, 100 percent of the Natives returned to Alaska, where 91 percent worked as primary care physician assistants in clinics serving predominantly

Native Alaskan communities. By comparison, 78 percent of the non-Native graduates returned to Alaska to work as physician assistants, 60 percent of them in primary care and 15 percent in predominantly Native Alaskan communities. There were no significant differences in salary or benefits between Native and non-Native graduates. Researchers conclude that physician assistant training for entry-level health workers is a viable strategy for increasing the number of underrepresented minorities in the health professions. The Native Alaskan graduates of MEDEX Northwest are returning to communities where they serve people both as health care providers and as professional role models. 3 figures, 4 tables, 16 references. (HE9700070)

041

### **Procedure for the Selection of Nonprofessional Workers.**

**Form:** Journal article.

**Authors:** Goldstein, A.D.; Camp, B.W.

**Source:** HSMHA Health Reports. 86(6):533-536, June 1971.

**Abstract:** Where the needs are highest for more economical health, education, and welfare services, many agencies are trying to use unskilled community members to perform more economically some of the tasks that are normally the responsibility of professionals. It is not easy to select individuals for the role of community worker; during the initial years of hiring and training unskilled workers, many frustrations have resulted from the overriding goal of providing jobs for needy people with too little regard for the needs and abilities of those selected. Consequently, the rate at which many nonprofessional employees resign is nearly 100 percent in many localities. To help agencies avoid some of these difficulties, researchers developed a selection procedure to

increase the probability of job success in terms of performance and work longevity. The procedure permits evaluation of personal factors that had been previously associated with failure on the job, such as insufficient knowledge about the work requirements, lack of interest or motivation for working with the poverty population, lack of a basic knowledge of English, or disruptive home situations. The procedure included (1) an orientation to the work, (2) a structured group interview to evaluate motivation and capability for working with a poverty-level population, (3) group tests to establish whether the applicants had the prerequisite skills needed for communication and training, and (4) a structured individual interview to evaluate personal factors related to work stability. In the initial application of this selection procedure, 5 of 15 applicants, all members of minority groups who lived in the neighborhood in which they would serve, were accepted. All selected workers using the procedure have received excellent or good evaluation ratings from supervisors. 1 figure, 4 references. (HE9700326)

042

### **Recruitment and Training Issues From Selected Lay Health Advisor Programs Among African Americans: A 20-Year Perspective.**

**Form:** Journal article.

**Authors:** Jackson, E.J.; Parks, C.P.

**Source:** Health Education and Behavior. 24(4):418-431, August 1997.

**Abstract:** The use of lay health advisors (LHA's) to address the health disparity among African Americans is well documented and considered a culturally appropriate model of community health promotion. Important components of the LHA model include identification, recruitment, and training of



LHA's. The Community Health Education Program at the Duke University Medical Center in North Carolina provided one of the original frameworks for LHA recruitment and training, and its model serves as a useful guide for exploring the evolution of recruitment and training procedures in LHA programs for African Americans. In selecting LHA's, or indigenous natural helpers, the model's main criterion included the identification of persons who embody the combination of social, cultural, ethnic, environmental, and communication values, norms, and beliefs of the target population. The authors describe eight resources for LHA identification: (1) area organizations, (2) people in key organizations, (3) services with outreach workers in the area, (4) program coordinators, (5) previously trained lay health advisors, (6) volunteers, (7) multiple listing of a name in a community survey, and (8) network search. In conducting a literature review on recruitment methods used in African American LHA programs during 1970–1995, the authors found 48 different methods. Successful recruitment methods include (1) community-wide surveys, (2) ethnic organization, recommendations, (3) community or institutional leader participation, (4) inclusion of various community organizing techniques, (5) use of a well-established and well-connected African American community-based organization, and (6) hiring of a socially active African American community member. Recommendations for health educators seeking to recruit and train African Americans for LHA programs include (1) acknowledging the skills of the LHA's and not employing recruitment and training techniques that disrupt their existing roles in the community; (2) establishing protocols from a perspective of enhancing, expanding, and supporting the helping skills of LHA's; and (3) relying on the collective wisdom of the community to identify,

recruit, select, and train LHA's. 2 tables, 47 references. (HE9701116)

043

### **Role and Training of Health Education Aides.**

**Form:** Journal article.

**Authors:** Knittel, R.E.; Child, R.C.; Hobgood, J.

**Source:** American Journal of Public Health. 61(8):1571-1580, August 1971.

**Abstract:** The role of nonprofessionals has increased considerably with the advent of government-financed programs to aid disadvantaged persons and those with low incomes. Nonprofessionals have worked in the public health field for years, and the use of such personnel in overseas programs is well documented. In a training project for health education aides (HEA) in Chicago, Illinois, 20 persons with an educational level equivalent to high school were selected on the basis of their interest in the problems of ghetto residents. Many of the participants were former residents of slum areas who were motivated to help change the conditions there. The idea that the main task of the HEA's was to motivate to residents and change their attitudes about environmental sanitation practices. The project provided the aides (1) substantive training in the technical aspects of rodent and vermin control, (2) understanding of the motivational factors affecting the residents of the slum areas, (3) skills and understanding in the change of attitudes of slum residents towards their environment, and (4) skill in face-to-face contact with slum residents on a personal basis. The authors evaluated the program 16 months after its inception and found that the aides worked effectively. The HEA's agreed that short training periods of about 2 weeks, followed by



field experiences, were the best form of training. 23 references. (HE9700307)

044

### **Role of the Community Health Aide in Rural Alaska.**

**Form:** Journal article.

**Authors:** Caldera, D.; Daniels, S.; Ashenfelter, W.

**Source:** Arctic Medical Research. (Supplement):157-160, 1991.

**Abstract:** The Community Health Aide Program is a system of health care that has evolved over the last 40 years to meet the primary health care needs of Alaska Natives living in small remote communities up to 1,300 miles from the nearest professional health care facility. The program is administered by Native nonprofit corporations that contract with the federal government to provide health and social services to the communities in their region. Community health aides (CHA's) are the sole resident health care providers in the communities they serve. They are able to provide complete basic primary health care for 85 to 90 percent of the patients seeking services at the clinic. CHA duties and responsibilities include acute and emergency care, health surveillance and preventive services, and administrative and community health services. The areas in which CHA's perform best are acute care for common ailments and emergency care; they are less successful or minimally involved in the provision of preventive care, health surveillance, health education, clinic administration, and outreach programs. Because 96 percent of the CHA's are women, and the Alaska Native culture is male-and elder-dominated, with traditional roles for women centered in the home, CHA's face many challenges to their tasks of providing primary health care to their communities' residents.

CHA supervisors, consulting physicians, conferences, and teleconferencing opportunities provide support to the CHA. Program improvements, including implementing new work schedules designed to decrease CHA stress and burnout, raising salaries, and improving training, were made possible through a 200 percent increase in funding between 1989 and 1991. 5 references. (HE9700301)

045

### **Role of Volunteers: What Educators Need to Know.**

**Form:** Newsletter article.

**Author:** Chai, K.T.

**Source:** Nursing Staff Development Insider. 4(3):1, 8, May-June 1995.

**Abstract:** The author discusses what volunteer educators should know about their volunteers. The 1995 human resource standards developed by the Joint Commission on Accreditation of Healthcare Organizations require that each staff member's capability to perform his or her specific job responsibilities be assessed through the completion of an orientation process. The role of the volunteer is as varied as the types of organizations. Some perform direct patient care including feeding and transporting patients. In other organizations, volunteers provide information and clerical support and transport specimens. When organizations define the role of volunteers, they should include the elements of job training and assessment required to meet expectations of the position. (HE9700463)

046

**Starting Point: Empowering Communities to Improve Health: A Manual for Training Health Promoters in Congregational Coalitions.**

**Form:** Manual.

**Corporate Author:** Carter Center, Interfaith Health Program.

**Source:** Atlanta, GA, Carter Center, Interfaith Health Program, 52 p., 1997.

**Abstract:** This manual was designed to help congregations implement efforts to teach lay volunteers to become health promoters. In this role, trained volunteers identify the health needs of their individual congregations and work to find appropriate resources to meet them. The manual is divided into five sections: (1) The Atlanta Model for Lay Health Ministry describes the development of the Atlanta Interfaith Health Program, a congregation-based health promotion project using health workers and volunteers; (2) Training Congregational Health Promoters (CHP's) describes the participatory learning approach and the role of the trainer or facilitator, and outlines the CHP training sessions used in the Atlanta coalitions; (3) Development of the CHP Training Program describes the coordination of the training program, the selection of a trainer or facilitator, the recruitment of lay volunteers for training as CHP's, the location of training, the development of a training budget, and the planning of a commissioning service; (4) After the Training: Follow Through discusses the development of a support system for CHP's and the training of additional CHP's; and (5) Evaluation describes the continuing evaluation of the Atlanta program and the CHP Training Program. Appendixes include a list of resources for training, a covenant of congregational participation, ideas for meeting introductions, learning activities, organization

and listening activities, health-related activities, and evaluation tools. (HE9700736)

047

**Three Perspectives on Community Health Aides: Surveys of Health Aides, Consumers and Providers in Western Alaska.**

**Form:** Journal article.

**Authors:** Quick, R.; Bashshur, R.

**Source:** Arctic Medical Research. (Supplement):161-165, 1991.

**Abstract:** The Yukon Kuskokwim Health Corporation conducted surveys of health aides, consumers and providers of health services; one survey objective was to assess the performance of community health aides (CHA's). All non-CHA providers received a provider questionnaire; their response rate was 87.8 percent. All CHA's were mailed a CHA questionnaire, with telephone follow up; their response rate was 96.7 percent. The consumer survey used a two-stage probability sample. Trained interviewers surveyed households, achieving a completion rate of 74.7 percent (473 of 633 households). The survey results showed that the majority of non-CHA providers were not Alaskan Natives and were married females over age 34 years, most households were headed by Eskimo males over age 39 years, and the majority of CHA's were married females over age 24 years, with annual family incomes of less than \$10,000 and with child care responsibilities. Most non-CHA providers rated the services provided by the CHA's as excellent or good (74 percent). According to consumers, the quality of care provided by CHA's compared favorably to the quality of care of other providers. As income and education levels increased among the consumers, use of CHA's as a source of general health information decreased. The majority of



CHA's said their job was stressful. The most stressful aspects they cited were inadequate pay, dealing with emergencies, and patients demanding treatment. The authors concluded that because high stress and low pay have contributed to high CHA turnover, increasing pay and reducing stress would appear to be potential solutions to the CHA turnover problem. Improving retention of CHA's would improve village health care. 4 tables, 13 references. (HE9700098)

048

**Use of Aides in Preventing an Outbreak of Diphtheria in a Housing Project.**

**Form:** Journal article.

**Author:** Branch, G.B.

**Source:** HSMHA Health Reports. 86(1): 92-96, January 1971.

**Abstract:** A case of diphtheria gravis reported in a 6-year-old boy living in a Los Angeles housing project in November 1964 aroused fear of an epidemic of the unusually virulent disease, which is associated with high mortality rates. As soon as the empirical diagnosis of diphtheria was made, the district health officer met with the manager of the housing project, the district health educator, and the director of the community center. The housing project had 3,100 residents living in close proximity; 1,200 of them were children under age 6 years; and 10 families shared a yard and play area. It was decided that an all-out effort would be made to immunize at least 80 percent of the children in the housing project who were under age 6 years (all the older children were offered diphtheria-tetanus toxoid immunizations at school). Health department representatives sponsored three clinics in the area at 1-month intervals, furnished all immunization materials, and taught neighborhood aides about the communicability of diphtheria and its control.

Neighborhood aides visited each family that had been exposed to the disease and explained the nature of diphtheria, and told them that a physician and nurse would come to their home to take specimens and give injections. A public health nurse obtained nose and throat specimens from all exposed people; 50 persons had positive cultures. Two aides, all members of the community center that assigned them to the task of helping to prevent the spread of diphtheria, worked together in 10 units with the housing project. The district health educator and the neighborhood aides met at the housing project to plan the immunization clinics and were involved in all areas of the program. The aides (1) suggested clinic sites and times of service based on their knowledge of community preferences; (2) designed forms and flyers; (3) selected health education materials; (4) made door-to-door contacts with project residents; (5) recruited one person in each block (block captains) to remind parents the day before the clinic was scheduled; (6) taught the block captains about diphtheria and interviewing; and (7) compiled data on who had received first, second, and third injections or booster shots and who needed further shots. At the end of the series of three clinics, 963 children under age 6 years (80.3 percent) and 119 other persons had received the 3 immunizations that resulted in adequate protection. 2 tables, 4 references. (HE9700343)



049

### **VISTA Means Vision: Three Winning Strategies for Training Diverse Outreach Workers.**

**Form:** Manual.

**Authors:** Morrow, G.; Andersen, R.; Tripp, M.

**Source:** Austin, TX, Texas Department of Health, 24 p., n.d.

**Abstract:** VISTA Means Vision: Three Winning Strategies for Training Diverse Outreach Workers is a manual published by the Texas Department of Health. Functioning as lay health educators, 300 Volunteers in Service to America (VISTAs) in the Texas VISTA Health Corps currently provide effective outreach in communities across the state. During the first 2 years of the corps, three successful training strategies have emerged. The first strategy involves collaboration. Three programs of the Texas Department of Health Immunizations, the Special Nutrition Program for Women, Infants, and Children (WIC), and the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) forged a partnership to create and sustain the Texas VISTA Health Corps. The training process encourages Texas VISTA Health Corps workers to replicate this collaboration in their own activities in order to achieve a unified approach to outreach for preventive health care services. The second strategy involves diversity. VISTAs in Texas are drawn from different backgrounds and have a variety of abilities, perspectives, languages, and levels of literacy. The materials are easy to read, simple to use, and incorporate principles of experiential and adult learning. The third strategy is empowerment. During orientation, Texas VISTAs are guided through exercises that encourage them to accentuate their strengths, contribute to a team, and develop synergy. This manual highlights training techniques, materials, and manuals that have been

developed for, and evaluated by, members of the Texas VISTA Health Corps. It includes an analysis of a training tool designed to empower Texas VISTAs to make a contribution to improving access to preventive health services for women and children and to realize important personal gains through the process. (HE9700468)

050

### **Women's Wellness Sourcebook: Module I: Introduction to Health and Wellness.**

**Form:** Teaching guide.

**Authors:** Jackson, T. ed.; Lasco, M.L. ed.; Calley, S.; Henning, M.; Linton, K.; Loosli, M.; Tamasabi, S.; Rivett, S.

**Source:** Sterling, VA, INMED, 82, 1997.

**Abstract:** This guide is the first in a series of six modules designed for trainers of health advisors. The adaptable curriculum in each module can be used independently or in combination with other modules. The six modules are Introduction to Health and Wellness, Cancer, Disease and Stroke, Diabetes, Healthy Lifestyles, and Aging. The training is based on the shared learning experience model, requiring the active involvement and participation of trainees. The training activities help participants identify their strengths, share their experiences, and combine efforts to create an effective community health program. Each unit in the module contains an overview, objectives, a timetable, an outline of the topics covered, a list of materials needed, information on advance preparation needed, and the trainer's notes. The trainer's notes contain guidance to each activity, points to emphasize, training tips and techniques, and summary suggestions. Module I consists of four units, which can be taught in two and a half days. Unit 1, Introduction to the Training, gives the trainer an opportunity to introduce individual program

goals and objectives, and gives the trainees an opportunity to try their new roles as health advisors. Unit 2, Understanding Wellness, offers relaxation and stress reducing techniques to the advisors. In Unit 3, Communication Skills for Health Advisors, trainees learn the basics of communication skills needed to gain the trust and acceptance of those they help. Unit 4, Playing an Active Role in Your Health Care focuses on negotiating the health care system, including self-advocacy. (HE9800122)

051

### **Women's Wellness Sourcebook. Module V: Health Lifestyles.**

**Form:** Teaching guide.

**Authors:** Jackson, T. ed.; Lasco, M.L. ed.; Calley, S.; Henning, M.; Linton, K.; Loosli, M.; Tamasabi, S.; Rivett, S.

**Source:** Sterling, VA, INMED, 141, 1997.

**Abstract:** Women's Wellness Sourcebook: Module V: Health Lifestyles is the fifth in a series of six modules designed for trainers of health advisors. The adaptable curriculum in each module can be used independently or in combination with other modules. The training is based on the shared learning experience model, requiring the active involvement and participation of trainees. The training activities help participants identify their strengths, share their experiences, and combine efforts to create an effective community health program. Each unit in the module contains an overview, objectives, a timetable, an outline of the topics covered, a list of materials needed, information on advance preparation needed, and the trainer's notes. The trainer's notes contain guidance to each activity, points to emphasize, training tips and techniques, and summary suggestions. This fifth module was written to teach health advisors how to make lasting changes in their community's health habits and behaviors.

Specific information is provided in units about smoking, nutrition, exercise, and AIDS and other sexually transmitted diseases (STD's). Unit 1 covers the role of the health advisor in supporting healthy lifestyles. Unit 2, Smoking Cessation, covers topics of facts on smoking, effects of secondhand smoke, positive effects of smoking cessation, preparing your clients to quit, and relapse prevention. Unit 3, Nutrition, includes information on the importance of a balanced diet, what constitutes a balanced diet, nutrients, achieving and maintaining a healthy weight, eating disorders, and assisting clients in planning healthier diets. Unit 4, Exercise, discusses the importance of exercise, aerobic exercise, weight training and flexibility training, making time for exercise, and walking. Unit 5, STD's, (HIV), and AIDS, covers sexual attitudes, understanding and explaining STD's and HIV, preventing transmission, and a practice session. A list of recommended resources is included. (HE9800126)





# The Community Health Advisor/Worker

## Volunteers as Community Health Advisors

052

### **Coordinating a Volunteer Program.**

**Form:** Journal article.

**Author:** Pettinelli, V.D.

**Source:** Mental Hygiene. 55(4):516-518, October 1971.

**Abstract:** The author presents the view that the success of any volunteer program is directly dependent on the skill and awareness of the volunteer coordinator. Before a program begins, the coordinator must first assess the climate in which the staff will function. The three basic elements to an effective volunteer program are: (1) selection, (2) training and supervision, and (3) communication. The selection of volunteers is the first vital step in establishing a sound volunteer work force. The coordinator must (1) be cognizant of the type of setting in which the volunteers will be placed, (2) assess the needs of the setting, and (3) seek to meet those needs by effectively use the skills of the volunteers. Volunteer training should begin immediately after the selection process is completed. The training should center on providing (1) a knowledge base that the volunteer may use to do the job more effectively and (2) an atmosphere for personal growth and development. The coordinator should establish good communication links with the volunteers. The volunteer coordinator must be sensitive enough to meet the needs of the agency as well as to meet the needs of the people who are giving freely of their time and abilities. (HE9700336)

053

### **Developing a Hospital's Volunteer Program.**

**Form:** Journal article.

**Authors:** Sues, A.M.; Wilson, P.A.

**Source:** Health and Social Work. 12(1):13-20, Winter 1987.

**Abstract:** Using experiences gained from the social service department of a 250-bed urban hospital that successfully initiated a volunteer program, two social workers explore the benefits of volunteer services to hospital social services departments and outline a systematic approach to developing volunteer programs that avoids common pitfalls and is both effective and cost conscious. Direct service to patients is perhaps the most common and valued volunteer activity. Volunteers also can play significant roles in administrative and clerical functions, public relations, fund raising, and policy and planning functions. Developing a volunteer program involves conducting (1) a detailed survey of potential sources of community volunteers, (2) an administrative audit to assess the need for volunteer services, (3) a cost-benefit analysis of the financial consequences of initiating such a program, and (4) a pilot program to evaluate design effectiveness. Difficulties that can undermine a volunteer program include (1) finding adequate volunteers, (2) defining the hospital auxiliary's relationship to the volunteer program, (3) contending with staff members' past experiences with and attitudes toward volunteers, and (4) giving inadequate attention to the costs of initiating and maintaining a viable volunteer program. 3 tables, 22 references. (HE9700069)

054

**Effective Hospice Volunteers:  
Demographic and Personality  
Characteristics.**

**Form:** Journal article.

**Authors:** Caldwell, J.; Scott, J.P.

**Source:** American Journal of Hospice and Palliative Care. 11(2):40-45, March-April 1994.

**Abstract:** The authors examined the demographic and personality characteristics of highly effective hospice volunteers. Researchers asked directors and coordinators at 50 hospice programs in Texas to identify their most dependable and effective volunteers. Volunteers were asked to complete a survey questionnaire. A total of 244 questionnaires were distributed and 156 (64 percent) were completed. The instruments assessed demographic information, degree of religious activity, community volunteer involvement, previous death experiences, and Myers-Briggs Type Indicator. Researchers used a nonparametric binomial goodness-of-fit test to compare volunteers' personality types to normative distributions. The mean age of the participants was 55.6 years, with ages ranging from 20 to 86 years. The sample was predominantly female (87 percent). The ethnic distribution of the sample was 95.3 percent white, 2.7 percent black, 1.3 percent Hispanic, and 0.7 percent other. Almost three-fourths of the participants were married, 18.3 percent were widowed, 5.9 percent were divorced, and 3.3 percent were single. They had a mean educational level of 14.6 years, with an educational range of 8 to 20 years. Nearly half of the participants were retired, 22.2 percent were employed in the home, 19.0 percent were employed full-time, and 11.1 percent were employed part-time. Overall, volunteers were predominantly white, female, and had above

average incomes. Results from the binomial goodness-of-fit test indicated that the proportion of extroverted and sensing types according to the Myers-Briggs Type Indicator was significantly higher in the present study than might be expected in the general population. The knowledge derived from this study may help coordinators to more effectively reach, train, and retain volunteers who can make a significant difference in hospice care. 3 tables, 20 references. (HE9700317)

055

**Factors in Achieving a Stable Group of  
Volunteers in a Mental Health Agency.**

**Form:** Journal article.

**Authors:** Furedy, R.L.; Kirschner, C.

**Source:** Hospital and Community Psychiatry. 26(3):167-168, March 1975.

**Abstract:** The authors discuss the factors that consistently influence the length of time a volunteer stays with an agency. Four factors are particularly important: (1) rites of passage, (2) life experience and task assignment, (3) supervision, and (4) group cohesiveness. Regarding rites of passage, the screening, orientation, and ceremony surrounding an individual's entrance into the volunteer group are vital. Volunteers should feel that their abilities are appreciated. During orientation, the volunteer sees what the job is really like, and decides whether or not to continue to work with and be identified with the agency. On the issue of life experience and task assignment, volunteers' own life experiences are the foundation for their beginning efforts to help clients. These experiences may or may not have positively prepared the individuals for the specific volunteer requirements. Volunteers arrive with a variety of ambitions, interests, and potential abilities, all of which must be closely matched to the specific task to be performed in



order for the volunteers to be satisfied and successful. Supervision is one of the best and most important ways for the agency to give to the giver. A supervisor has a great deal to teach and must help the volunteer understand the client's behavior, feelings, and perceptions. Finally, a volunteer's identification with, and sense of belonging to, the volunteer group is necessary for forming a cohesive bond with the agency. The wish for social contact is often a major but unspoken motivation for volunteering. Other important actions to maintain volunteers include electing volunteers to the agency's board of directors and ensuring that volunteers are full partners in every aspect of the agency's operations. (HE9700327)

056

### **Hospice Caregiving: Strategies to Avoid Burnout and Maintain Self-Preservation.**

**Form:** Journal article.

**Author:** Patrick, P.

**Source:** Hospice Journal. 3(2-3):223-253, Summer-Fall 1987.

**Abstract:** A psychologist describes methods for hospice caregivers to assess their level of stress and burnout, identifies aspects of personal growth and change influencing self-care, and outlines key self-care strategies that support self-preservation. The health professional offers two methods for gaining a more individualized understanding of current manifestations of burnout and negative stress: (1) the Social/Interpersonal, Emotional, Physical, Spiritual Assessment Inventory and (2) the Support System Grid. Promoting self-preservation requires (1) committing to the development of a self-care plan; (2) adopting a proactive preventive approach that includes ongoing self-assessment activities, implementation of self-care strategies before signs or symptoms of burnout appear, and

consistent monitoring of personal progress; (3) avoiding resistance to changing behavior; and (4) approaching behavior change systematically. Strategies for self-preservation emphasize (1) physical self-care (i.e., fitness, relaxation, nutrition, and habit control); (2) psychological/emotional self-care strategies (i.e., personal support system, support group, recreation and play strategies, planning, and goal and limit setting); (3) strategies for reaching out; and (4) spiritual self-care strategies. As hospice caregivers recognize the interrelatedness of caring for others and oneself, the services provided patients and families will be enriched. 3 figures, 17 references. (HE9700076)

057

### **Patient Care Training Program for Volunteers.**

**Form:** Journal article.

**Authors:** Walker, P.W.; Ross, M.J.

**Source:** Journal of Nursing Staff Development. 5(4):180-182, July-August 1989.

**Abstract:** Two nurses describe the planning and implementation of a training program for lay community volunteers to assist with basic health care at the Eilson Air Force Base near Fairbanks, Alaska. In planning the program, developers (1) assessed precisely what a volunteer would need to know and do in each of the clinical areas; (2) informally interviewed the supervisors of each patient care area for their ideas concerning what specific knowledge and skills volunteers should have; (3) assessed the possible skills, experience, and level of education of the average potential volunteer; and (4) consulted a number of sources for a simple step-by-step approach to adult education programs. The week-long orientation course used guest speakers, movies, slides, overhead transparencies, videos, role-playing, and actual



hands-on experience to supplement lecture. Process evaluation was an important tool in the daily schedule. As necessary, they changed presentations to meet the levels of understanding. The course concluded with 4 hours of supervised clinical time in the patient care area of the volunteer's choice. At the end of the course, the volunteers completed an evaluation questionnaire. The program was modified to incorporate the volunteers' suggestions. After the volunteers had worked for 5 weeks, their supervisors completed an evaluation of the competency of these trained volunteers and rated them highly in both skills and knowledge. The authors conclude that qualified and adequately trained volunteers could offer great potential service in patient care areas that are understaffed with nursing personnel. 1 figure, 4 references. (HE9700051)

058

### **Planning: The Key to a Successful Volunteer Program.**

**Form:** Journal article.

**Author:** Trocchio, J.

**Source:** Journal: American Health Care Association. 1(1):72-73, July 1975.

**Abstract:** Volunteer programs often collapse because of poor planning. Adequate planning can produce a vital, creative volunteer program that benefits nursing home residents, the facility administration and staff, and the community in which the facility is located. Four steps must be considered in program planning: (1) assessment of the need for volunteers, (2) identification of community resources, (3) development of program objectives, and (4) definition of policies. Step one requires an identification of needs that are appropriate for volunteers to meet. Residents and staff should be involved in this early

planning stage. Step 2 is exploration of the volunteer market. Every facility will have different resources available. The staff may be interested in helping with parties and activities outside their working hours. Nursing home residents themselves are an excellent volunteer resource, and their visitors also may be pleased to have interesting projects in which to be involved along with their regular visits. Step 3 is the definition of program objectives, which should include (1) the goals of the program, (2) the number of volunteers to be recruited, (3) the expected benefits to the operation of the facility, and (4) desired projects and activities. Step 4 involves policy making. Volunteers should know what to expect and what is expected of them. Policies should include (1) the recruitment procedure, (2) an outline of an initial interview with prospective volunteers, (3) job descriptions for volunteers, (4) an outline of an orientation program, (5) means to evaluate the program and the individual volunteers, and (6) methods by which the facility can thank the volunteers and recognize volunteer achievement. All nursing home personnel should be involved in the formation of volunteer policies. If the planning is a collaborative effort among the facility's administration, staff, residents, and community, a successful volunteer program can be established, and a dynamic relationship will develop within the home. 2 references. (HE9700338)

059

**Rural Emergency Medical Volunteers and Their Communities: A Demographic Comparison.**

**Form:** Journal article.

**Author:** Thompson, A.M.

**Source:** Journal of Community Health. 18(6):379-392, December 1993.

**Abstract:** Researchers compared the personal, household, and professional characteristics of volunteer emergency medical service (EMS) providers in Ulster County, New York, with those of the general population of this rural upstate county, using data from the 1990 U.S. Census of Population and Housing. The purpose was (1) to evaluate the ability of EMS squads to recruit new and retain current members from their communities and (2) to ascertain the level of commitment of EMS volunteers to their squads and communities. Researchers gathered EMS volunteer attributes by a parallel survey that they administered to members of all nine volunteer EMS squads in the county. Researchers supplemented the questionnaire with in-depth interviews with several of the active volunteer EMS providers, as well as with direct observation of the full range of activities in which these EMS squads engage. Statistically significant deviations between the two sample populations included (1) age distribution, (2) maximum educational attainment, (3) size of household, (4) years in residence, (5) type of employer, (6) employing industry, (7) occupation, (8) household income, and (9) commuting distance from work. Differences for (1) race, (2) sex, (3) marital status, (4) household site, (5) home ownership, (6) housing costs, and (7) in-county employment were not statistically significant. The author believes that the research provided a reasonably detailed and useful portrait of EMS volunteers by comparing several of their

socioeconomic attributes with those of their fellow citizens. The data provided substantial evidence of the volunteers' loyalty and commitment to the EMS, indicated by a statistically significant positive correlation between the volunteers' age and length of service. Of polled EMS volunteers, 45 percent claimed they never considered resigning and an additional 27 percent considered resigning only rarely. The dominant causes cited for considering resigning were personal time constraints and internal dissatisfaction with the EMS squad itself. Fifty-four percent of EMS volunteers had relatives who also volunteer in this capacity and 30 percent state that they were married to, or otherwise involved with, another EMS volunteer. 4 tables, 14 references. (HE9700056)

060

**Training Imperatives for Volunteers Caring for High-Risk, Vulnerable Populations.**

**Form:** Journal article.

**Authors:** Hutchison, R.R.; Quartaro, E.G.

**Source:** Journal of Community Health Nursing. 10(2): 87-96, 1993.

**Abstract:** Educators associated with the Homeless Shelter Program, a network of churches and synagogues in a northeast suburban area, identify the caring needs of both high-risk, vulnerable populations and of the volunteers serving them and present a training program as a model applicable to the training of those volunteers. The program, which provides two meals daily, sleeping accommodations, and evening activity programs, is dependent on volunteer services. The needs of high-risk, vulnerable populations include (1) survival requirements such as food, clothing, and shelter; (2) planning for adequate and appropriate health care; (3) understanding and



supportive interactions with professional and volunteer personnel; and (4) strengthened family ties, where they exist. Following a three-step assessment of volunteer needs and an extensive literature review, the educators developed a three-session curriculum for training volunteers based on the interdisciplinary foundation of nursing and social work substantive areas. Program outcomes for volunteers included an enhanced ability to relate to persons in high-risk, vulnerable populations with less anxiety, greater ease, and less distancing from the person served. The researchers concluded that using a corp of well-trained volunteers frees professional staff to perform high-level services in a program. 20 references. (HE9700052)

061

### **Training of Telephone Crisis Intervention Volunteers.**

**Form:** Journal article.

**Authors:** Dixon, M.C.; Burns, J.

**Source:** American Journal of Community Psychology. 3(2):145-150, June 1975.

**Abstract:** The authors review seven articles that address selection and training of telephone crisis intervention volunteers. Brockopp and Yasser discuss volunteer training for telephone therapy, using the Erie County Suicide Prevention Center as a model. They emphasize selection, phased training, supervision and feedback on individual performance, and follow-up to the training program. Reisman describes the essential components of a training program: role clarification, phased training that progresses into all areas a volunteer may encounter, and unified criteria used in the selection of the volunteers to strengthen individual weaknesses. He stresses that unrealistic expectations should not be created for volunteer trainees. Lamb's paper on errors

and fallacies found in telephone therapy points out that telephone therapists must not believe they are perfect; nor should they enter into their work with an inflexible approach to problem solving. The goal of training should be the prevention of errors. Heilig, Farberow, Litman, and Shneidman discuss the selection and training of nonprofessionals for telephone therapy in suicide prevention. They stress three primary training areas: adequate coverage of theories relevant to telephone therapy and suicide prevention, practice in specific methods for handling calls, and example of actual calls and case histories. An apprenticeship after training should address and try to resolve specific weaknesses for each volunteer. Farberow, in discussing training at the Los Angeles Suicide Prevention Center, emphasizes the importance of removing existing feelings about the social stigma of emotional and mental health problems from the volunteers during training. Fowler and McGee present a scale to assess the effectiveness of volunteer telephone workers. Based on their review, the authors of the articles conclude that there is no systematically developed rationale for either the selection or the training of crisis call volunteers. The authors suggest that training for nonprofessional or lay volunteers be based on the concepts of crisis intervention and on social learning principles. 15 references. (HE9700334)

062

### **Training Volunteers as Alcoholism Treatment Counselors.**

**Form:** Journal article.

**Author:** Manohar, V.

**Source:** Quarterly Journal of Studies on Alcohol. 34(3):869-877, September 1973.

**Abstract:** This article describes a training program developed by the Harvard Medical



School to maximize the services delivered by the Alcoholism Division at the Boston City Hospital. The Alcoholism Division operated two evening outpatient clinics and a daytime drop-in system, and offered training, consultation, and research. The 14-month training program, which was open to members of the community, students, and professionals, aimed to prepare the trainees to provide direct care in an individual or group setting, to make effective referrals, and to coordinate care while working with professionals and other community agencies. The content of the course varied according to the needs and interests of each particular training group. Classroom work was supported by mandatory and supplementary reading. Trainees also visited the clinic to observe treatment from a patient's perspective. After completing the coursework, trainees spent 4 hours a week in interaction with patients, attend staff meetings, and the continuing education program. The presence of a large, qualified group of volunteer counselors helped the clinic to attract and treat more patients. 8 references. (HE9700341)

063

**Understanding Volunteer Peer Health Educators' Motivations: Applying Social Learning Theory.**

**Form:** Journal article.

**Authors:** Klein, N.A.; Sondag, K.A.; Drolet, J.C.

**Source:** Journal of American College Health. 43(3):126-130, November 1994.

**Abstract:** Researchers conducted five focus group interviews with students who were peer educators at a midwestern university to determine what factors motivate students to volunteer for a peer health education program. Interview questions explored students' life experiences, their expectations of the peer

education program, and their motivations. Constructs from social learning theory were used to categorize and contribute to understanding of the responses. Many participants specified experiences with family members or friends, such as alcoholism or other illnesses, that influenced their decisions. The peer health educators' motivations for volunteering were altruistic, such as wanting to help others; egoistic, such as wanting job training; or related to self-efficacy beliefs, such as satisfying a personal need for health education. Volunteers were influenced to join by their life experiences, a belief in the effectiveness of peer health education programs, and positive reinforcement to join. 26 references. (HE9500174)

064

**Use of Volunteers in a Community Mental Health Center Emergency and Reception Services: A Comparative Study of Professional and Lay Telephone Counseling.**

**Form:** Journal article.

**Authors:** O'Donnell, J.M.; George, K.

**Source:** Community Mental Health Journal. 13(1):3-12, Spring 1977.

**Abstract:** Researchers tested a model of community participation in the emergency and reception service of a community mental health center by comparing telephone counseling effectiveness of volunteers to the effectiveness of the center's professional staff. After recruitment and a selective screening process, volunteers receive 15 hours of didactic and experiential training in crisis theory, effective interpersonal communication, and use of community resources, and 15 hours minimum of closely supervised on-line experience with callers. Ongoing refresher training is conducted for all volunteers at approximately 6-week

intervals. Four groups of 10 persons each participated in a study of telephone counseling effectiveness: 10 community mental health center professional staff (Group P), 10 experienced telephone hotline volunteers with a minimum of 1 year of experience per volunteer (Group EV), 10 recently trained but inexperienced volunteers (Group IV), and a control group (Group C) comprised of 10 college sophomores having had no involvement with, or intention to, volunteer for telephone hotline work. Researchers instructed 40 college sophomores in role playing and randomly assigned a typical crisis telephone problem to present to an anonymous counselor over the telephone. Role-playing callers completed a consumer satisfaction questionnaire providing a subjective rating of the counselor's helpfulness. All calls were recorded and replayed for objective rating by two pairs of advanced psychology student raters. Assessment criteria consisted of modified scales from the Carkhuff (1969) Scales for Assessment of Interpersonal Functioning and additional scales. Professionals, experienced trained volunteers, and inexperienced trained volunteers scored significantly higher than did untrained control participants. Researchers report that carefully selected and trained volunteers can function as effectively as professional staff in providing supportive and emergency telephone services for distressed callers and community mental health center clients. 2 figures, 1 table, 30 references. (HE9700065)

065

### **Volunteer Stress and Burnout: Issues for Administrators.**

**Form:** Journal article.

**Authors:** Paradis, L.F.; Miller, B.; Runnion, V.M.

**Source:** Hospice Journal. 3(2-3):165-183, Summer-Fall 1987.

**Abstract:** In this article, two health professionals identify primary stressors experienced by volunteers who provide direct patient care, based on information collected through investigations on volunteer characteristics at five research sites, informal chats with volunteers at state and national hospice meetings, and formal interviews with hospice volunteers and volunteer coordinators. To investigate sources of stress, the researchers randomly selected and interviewed 38 volunteers (ages 18 to 65 years). Volunteers were asked to identify stressors in their volunteer experience, problems related to training, the length of time they intended to stay with the program, and their reasons for staying or leaving. On the basis of volunteer responses, researchers grouped volunteer stress into four areas that included (1) role ambiguity, (2) status ambiguity, (3) patients and families, and (4) stress caused by the volunteer's personal circumstances. Researchers recommend that volunteer coordinators develop an interview guide to screen community volunteers for their ability to handle sensitive issues in death and dying and to cope with grief and loss, and provide an ongoing training program, stress-reduction support groups, and evaluation of each training session. 30 references. (HE9700075)



# The Community Health Advisor/Worker

## Evaluation

066

### **Community Health Aides: How Effective Are They?**

**Form:** Journal article.

**Authors:** Cauffman, J.G.; Wingert, W.A.; Friedman, D.B.; Warburton, E.A.; Hanes, B.

**Source:** American Journal of Public Health. 60(10):1904-1909, October 1970.

**Abstract:** This article discusses a study conducted in the Pediatric Emergency Room (PER) of the Los Angeles County-University of Southern California Medical Center to measure the ability of community health aides to perform in an educational capacity related to patient care. Researchers hypothesized that mothers instructed by community health aides would be as likely to comply with Physicians' Upper Respiratory Infection (URI) Order Lists as would mothers who were instructed by public health nurses or by physicians. Project staff recruited and trained community health aides to teach mothers how to care for their children when they had an upper respiratory infection. The aides were either of African American or Spanish surname backgrounds, (the dominant ethnic groups attending the PER) had a high school education, and ranged in age from 18 to 35. Two pediatricians, two public health nurses, and a health educator trained the aides. Mothers were randomly assigned to the aides, to nurses, or to physicians to receive instruction about their children's URI. After identifying a child's illness as a URI, the physician asked the mother to follow from 1 to 11 orders on the Physicians' URI Order List. A mother was classified as having followed the Physicians' Order List only if she followed all of the URI orders that were assigned to her at

the PER. If a mother did not perform all of the orders, she was classified as not having followed the physician's orders. An analysis of the data indicated that there was no difference in compliance among mothers who were instructed by community health aides, by public health nurses, or by physicians. This project demonstrated that aides can be trained to assume important responsibilities in maternal education. 1 table, 14 references.  
(HE9401371)

067

### **Comparative Effectiveness of Professional and Paraprofessional Helpers.**

**Form:** Journal article.

**Authors:** Hattie, J.A.; Sharpley, C.F.; Rogers, H.J.

**Source:** Psychological Bulletin. 95(3): 534-541, May 1984.

**Abstract:** Researchers demonstrate the usefulness of meta-analysis procedures to resolve many of the unresolved differences between researchers Durlak, Nietzel, and Fisher on the relative effectiveness of professional and paraprofessional counselors. Although the authors agree that greater use is being made of paraprofessionals in the mental health field than previously, they disagree on the value of such use. Using a box score analysis of 42 studies, Durlak concluded that the clinical outcomes paraprofessionals achieve are equal to, or significantly better than, those obtained by professionals. Nietzel and Fisher disagreed, arguing that in many instances the research design used was inappropriate to the effectiveness issue, the definition of terms was suspect, and the design and power of many of



the 42 studies were questionable. Effect sizes based on 154 comparisons from 39 studies indicated that clients who seek help from paraprofessionals are more likely to achieve resolution of their problem than those who consult professionals. The more experienced the paraprofessionals, the greater their effectiveness as compared with professionals. However, the more recent the training of the professional, the greater the effect. The researchers' conclusion is supportive of, but is not as strong as, Durlak's conclusion that paraprofessional achieve clinical outcomes equal to, or significantly better than, those obtained by professionals. According to the authors, evidence demonstrates that paraprofessionals must be considered effective additions to the helping services. 1 table, 25 references. (HE9700084)

068

### **Developing a Tool to Record Changes: Impact of EFNEP on Some Nutrition-related Practices.**

**Form:** Journal article.

**Authors:** Murphy, M.J.; Smiciklas-Wright, H.; Heasley, D.K.; Hamilton, L.W.

**Source:** Journal of the American Dietetic Association. 76(6):570-574, June 1980.

**Abstract:** Researchers describe a nutrition evaluation instrument designed to measure food storage and safety, kitchen sanitation, and food money management by families participating in the Expanded Food and Nutrition Education Program (EFNEP). The goal of the EFNEP, administered by the Cooperative Extension Service of the U.S. Department of Agriculture, is to improve the diets and nutritional practices of disadvantaged, hard-to-reach families through individualized, home-based instruction. The evaluation was intended (1) to collect uniform data to standardize program evaluation,

(2) to provide a diagnostic tool to help assess a homemaker's progress and to determine appropriate educational strategies for informing the homemaker, and (3) to serve as a progress record to help the nutrition aides more easily identify any success and improvement in working with families. Pennsylvania nutrition aides tested the evaluation instrument to determine whether a correlation exists between the length of time a homemaker participates in the EFNEP and her performance with regard to nutrition-related practices. Variable controls included (1) the length of time a homemaker had participated in the EFNEP, (2) the homemaker's place of residence, (3) the homemaker's education level, (4) family income, and (5) number of children in the home. The instrument revealed a trend toward improved performance but not a strong, statistically significant correlation. Aides' comments reflected compassion, practicality, sharp insight, and a strong loyalty to their program families. Researchers believe that this demonstrates, in part, insufficient emphasis on nutrition-related practices and suggest that more training and teaching materials addressing nutrition practices are needed. 4 tables, 6 references. (HE9700067)

069

### **Economic Evaluation of Home Visiting Programs.**

**Form:** Journal article.

**Author:** Barnett, W.S.

**Source:** Future of Children. 3(3):93-112, Winter 1993.

**Abstract:** The author discusses an economic evaluation of home visiting programs. Economic evaluation can be used to improve home visiting policy and practice and to direct resources to the most effective programs. Measuring the costs and benefits of home

visiting programs includes (1) defining the scope of the analysis; (2) measuring the costs, estimating the program effects or outcomes, and placing monetary value on the effects; (3) accounting for the effects of time on costs of resources; (4) summing the calculations of the valuation of costs and outcomes across years and deciding which program is the best alternative; (5) describing who gains and who loses under each option; (6) identifying critical assumptions made in the analysis and exploring the effects of reasonable variations in those assumptions; and (7) describing the important program effects that cannot be monetarily valued or perhaps even quantified. The author discusses six studies that reviewed the cost-effectiveness of various home visiting programs that varied in their goals, methods, and target populations. The studies relied on narrow definitions of cost and placed value on selected benefits to which monetary values could easily be assigned. The studies were clustered into three groups: home visits after early hospital discharge, educational home visits combined with developmental child care and other services for low-income families, and health organization-sponsored home visits aimed at improving parental care of infants and child health and development. The authors suggest that the evaluation results show that two-generation programs that address the needs of parents and children can produce large benefits, and therefore appear to be an important focus for economic evaluation. Results also suggest a focus on interventions targeting low-income expectant mothers and other high-risk populations that have been found to be responsive to home visiting. An appendix outlines the nine essential steps involved in the cost-benefit evaluation of home visiting programs. 3 tables, 45 references.  
(HE9700606)

070

### **Effectiveness and Efficiency of Indigenous Health Aides in a Pediatric Outpatient Department.**

**Form:** Journal article.

**Authors:** Wingert, W.A.; Grubbs, J.; Lenoski, E.F.; Friedman, D.B.

**Source:** American Journal of Public Health. 65(8):849-857, August 1975.

**Abstract:** Investigators at the University of Southern California Medical Center sought (1) to determine whether 1 year of comprehensive health supervision could improve the health and social welfare of indigent families, and (2) to compare the effectiveness of professional public health nurses (PHN's) to that of supervised nonprofessional health aides in providing such health care supervision. Seven female health aides (ages 18 to 59 years) were recruited from the community served by the hospital. The training program for the health aides included 2 months of lectures, conferences, and demonstrations that included family problem identification and resolution, with continuous on-the-job instruction and weekly conferences thereafter for 10 months. The health aides performed a complete survey of a family within 1 month of program completion. At the end of the study, the project director and the PHN supervisor evaluated the aides' performance. Results indicate that the aides were able to collect and record data and perform a battery of technical multiphasic screening procedures as capably as highly educated professionals. Aides, however, could not identify problems as effectively as nurses and could not recognize major problems in all areas as well as PHN's. Aides and professionals did not differ significantly in their pediatric problem-solving ability, but the nurses proved superior to the



aides in helping adults. 4 tables, 15 references. (HE9700072)

071

**Evaluation of Social Problem Solving Abilities in Rural Home Health Visitors and Visiting Nurses.**

**Form:** Journal article.

**Authors:** Jessee, P.O.; Cecil, C.E.

**Source:** Maternal-Child Nursing Journal. 20(2):53-64, Summer 1992.

**Abstract:** Researchers compared the skills and abilities of a selected sample of women involved in home health care to suggest and then prioritize solutions to a client's medical problem. Participants were 77 females residing in rural counties in west Alabama. Home visitors who were trained, hired, and worked for more than 6 months in the Rural Alabama Pregnancy and Infant Health Program (RAPIH) constituted one group of black women. Home visitors who had finished training and were either not hired or had worked for less than 7 months constituted a second group (100 percent black). Home visiting nurses from the Alabama Public Health Services serving the West Alabama Health District constituted the third group. A group of black women from local communities who were recommended by project personnel served as the controls. Researchers used two instruments, The Practical Solutions Test (PST) and a Ranking of Solutions Procedure (RSP), to gather information. All of the trained groups were able to generate more solutions to a typical client medical problem than was the control group. The nurses group was more likely than the home visitors to suggest medical options over socioemotional solutions. The nurses also prioritized the solutions differently by ranking them in a different sequence. Researchers conclude that the primary emphasis on medical

topics seemed to be one of the factors that discouraged client participation in the RAPIH project during its first years of operation. When home visitors were selected for employment on the basis of personal qualities such as flexibility, empathy, and a strong sense of self, and when their training was redirected to provide mothers with a source of emotional support, client enrollment increased. 2 tables, 22 references. (HE9700058)

072

**Point of Diminishing Returns in Nutrition Education Through Home Visits by Aides: An Evaluation of EFNEP.**

**Form:** Journal article.

**Authors:** Wang, V.L.; Ephross, P.H.; Green, L.W.

**Source:** Health Education Monograph. 3(1):70-88, Spring 1975.

**Abstract:** To determine the point of diminishing returns in continuing visits to homemakers, investigators conducted a 3-year evaluation of field work among low-income, rural homemakers by nutrition aides employed by the Expanded Food and Nutrition Education Program (EFNEP) of the Maryland Cooperative Extension Service. Local aides were recruited, trained, and supervised by Extension staff. One of two experimental groups consisted of 49 EFNEP homemakers being visited by aides after 3 years in the program. The second experimental group consisted of 44 homemakers who had left the program after the end of their second year. The comparison groups consist of matched samples of 34 designated friends from the first experimental group members and 24 friends of the second experimental group members. End of service to homemakers in the second and third years was controlled by aides and homemakers, not by the investigators. The homemakers who continued



in the program were more economically dependent and socially disadvantaged than were the homemakers who left the program. The researchers suggest that major gains in nutritional adequacy, if any, were achieved in the first year of contact between aide and homemaker. The results suggest various points of diminishing returns beyond which behavioral and attitudinal changes are too small to justify continued home visits to a homemaker. In general, it appears that the third year of home visits is superfluous. If cost-effective home visits are to be sustained after the first year, more emphasis must be placed on reinforcement of first-year gains and on expanding the scope of nutrition education to include other kinds of health education.

7 tables, 9 references. (HE9700312)

073

### **Randomized Clinical Trial of Home Intervention for Children With Failure to Thrive.**

**Form:** Journal article.

**Authors:** Black, M.M.; Dubowitz, H.; Hutcheson, J.; Berenson-Howard, J.; Starr, R.H.  
**Source:** *Pediatrics*. 95(6):807-814, June 1995.

**Abstract:** The authors conducted a randomized clinical trial to evaluate the efficacy of a home-based intervention on the growth and development of children with nonorganic failure to thrive. The sample included 130 children recruited from urban pediatric primary care clinics serving low-income families. Eighty-nine percent of the families completed the study. All of the children were younger than age 25 months, with weight for age below the fifth percentile. The authors randomized the children into two groups: clinic plus home intervention, or clinic only. The children received services at a multidisciplinary growth and nutrition clinic. The group that had clinic

plus home intervention also received weekly home visits for 1 year. Three trained, lay home visitors conducted the home intervention, supervised by a community health nurse. Lay home visitors were selected for their experience with children and families, their interpersonal skills, their knowledge of the community, and their commitment. The lay visitors completed a training program that covered (1) children's health and nutrition, (2) infant and toddler development, (3) activities to promote children's development, (4) parent-child interaction, (5) behavior management, (6) relationship building, (7) family relationships, (8) child and family advocacy, (9) problem solving, and (10) community resources and services. The lay visitors provided maternal support and promoted parenting, child development, use of informal and formal resources, and parental advocacy. A nurse weighed and measured all of the children in the sample to assess wasting and stunting. The authors measured language development, along with cognitive and motor development, at recruitment and at the 12-month follow up. They also measured parent-child interaction by observing mothers and children during feeding at recruitment and at the 12-month follow up, and measured the quality of the home environment by the Home Observation Measure of the Environment 18 months after recruitment. Analysis showed significant improvement in weight for age, weight for height, and height for age during the study period, regardless of the intervention status. The authors concluded that home intervention by lay home visitors had a beneficial effect on infant cognitive and receptive language development and on the quality of the home environment. They also concluded that the home intervention might have been enhanced by including more specific activities targeted to the developmental needs of toddlers, along with links to other health and social service

programs. 3 tables, 70 references.  
(HE9600947)

074

**Three Years Later: An Evaluation of  
Volunteer Training.**

**Form:** Journal article.

**Author:** Pearse, D.T.

**Source:** Gerontologist. 6(3):154-158,  
September 1966.

**Abstract:** The author describes an evaluation of the Sargent House Project of the Episcopal Diocese of Washington (District of Columbia), which was conducted from 1959 through 1962 as a demonstration project to train volunteers to work with the elderly. Six training courses of 10 hours each were given. Training included course instruction and on-the-job supervision. A major purpose of the project was to stimulate the trained volunteers in developing programs for the aged in various locations throughout the metropolitan area. After the founding demonstration grant ran out, the project ended in June 1962. To evaluate the results of the training 3 years after the project ended, investigators sent questionnaires to the 15 continuing volunteers; 13 completed the questionnaire. Fourteen of the original 46 trained volunteers continued to provide services to a group of senior citizens in seven locations on a regular, continuing basis. Lack of any effective recruitment measures for both volunteer leaders and new participants, lack of funds, and the isolation of the groups from the host facility hindered the program's possible future progress. 2 references. (HE9700349)

## Health Promotion and Disease Prevention Programs

075

### **Activating Ideas: Promoting Physical Activity Among Older Adults. A Guide for Program Planners and Volunteer Leaders.**

**Form:** Manual.

**Author:** DiGilio, D.A.

**Source:** Washington, DC, American Association of Retired Persons, 65 p., 1994.

**Abstract:** This manual was designed for older adult volunteers and program planners who want to develop and promote exercise programs for older adults. The manual suggests strategies to encourage older adults to exercise regularly. Part 1, Physical Activity and Older Adults, includes (1) The Problem, (2) The Definition, (3) The Benefits, and (4) Beyond Benefits to Behavior. The second part, Program Strategies for Breaking Down Barriers, offers (1) Line Dancing Delivers, (2) Walking Works Wonders, (3) No-Pain and A-Lot-to-Gain Exercise, (4) Physician Prescriptions, (5) Self-Supporting Programs Survive, (6) Promote Peer-Led Programs, (7) Personalized Programs, (8) Bias-Buster Media Events, and (9) Bridging the Generation Gap. Part 3, A Variety of Activating Ideas, comprises (1) Down With Dropouts, (2) Marketing Tips, (3) Reaching the At-Risk, (4) Networking in a Nutshell, (5) Networking at the Local Level, and (6) Networking at the State/National Level. The fourth and final part, Resources, includes (1) Exercise Regimens and Activities, (2) Program Design and Management, (3) Journal Articles for Professionals, (4) Health Education Materials for Older Adults, (5) Marketing, and (6) Funding. (HE9601252)

076

### **Establishing Community Health Centers in Rural Appalachia Utilizing Lay Volunteers.**

**Form:** Newsletter article.

**Author:** Morris, F.J.

**Source:** Human Services in the Rural Environment. 3(1):1-4, January 1978.

**Abstract:** This article describes the establishment of 10 Community Health Centers in the homes of volunteers in communities throughout Harlan County, Kentucky, by the Southeast Community College Appalachian Leadership Community Outreach (ALCOR). ALCOR is a nonprofit, privately funded corporation working through six eastern Kentucky colleges to serve the residents of rural Appalachia. The Community Health Centers were established in response to the need of consumers in rural areas for health care in the community and as a way to provide continuous health care. At each of the 10 sites, ALCOR students trained a reliable and respected volunteer in basic first aid pressure measurements. The volunteers were provided with a stethoscope, pressure cuff, and booklets on blood pressure to distribute to community residents. Each center received a set of bathroom scales and a first aid kit containing a snake bite kit and a thermometer. The volunteers' homes became the location of various community health education programs. ALCOR students presented programs on the warning signs of cancer, breast self-examination using silicone breast forms with actual lumps, nutrition, dental hygiene, and coronary care. Screening tests for anemia, diabetes, sickle cell anemia, cholesterol, parasites, vision, hearing, and blood group and Rh, were available to community members at no charge. All positive findings were referred for follow-up care. (HE9700734)



077

### **Evaluation of Modeling-Role-Playing and Lecture-Discussion Training Techniques for College Student Mental Health Paraprofessionals.**

**Form:** Journal article.

**Authors:** Teevan, K.G.; Gabel, H.

**Source:** Journal of Counseling Psychology. 25(2):169-171, 1978.

**Abstract:** Researchers evaluated the relative effectiveness of modeling and role-playing and lecture-discussion training techniques for 45 college students who worked as mental health paraprofessionals. The college students that participated in the study were primarily female, were between 18 and 24 years old, and had no previous counseling training or experience. Participants were divided equally among three groups: (1) the lecture-discussion group, (2) the modeling and role-playing group, and (3) a control group. Both the lecture-discussion group and the modeling/role-playing group received 9 hours of training within a 2-day period and then completed assessment measures. The control group completed the assessment measures first and then received 9 hours of training. Training for both treatment groups focused on the initial skills and information necessary for a paraprofessional crisis-call counselor and included (1) crisis theory, (2) listening skills, (3) values in counseling, (4) drug counseling, and (5) suicide prevention techniques. Assessment measures included a written questionnaire and a small-group role play. Counselor statements were rated and mean empathy level was calculated for each participant. Initial statistical analyses indicated that there were no significant differences between groups, suggesting initial equivalence of the groups. However, results of the counselor statement ratings and mean empathy levels showed that the modeling and

role-playing group chose the highest number of appropriate responses and achieved higher ratings on empathy level and counseling skills. These results are consistent with earlier research that supports the idea that training does in fact lead to improved paraprofessional performance. Evidence shows that training techniques that incorporate modeling and role-playing are superior to lecture-discussion methods. The results can likely be applied to other training programs that share a goal of interest in development of rudimentary counseling skills in a relatively brief training period. 1 table, 15 references. (HE9700615)

078

### **Increasing Participation in Health Promotion Among Older African-Americans.**

**Form:** Journal article.

**Author:** Williams, M.P.

**Source:** American Journal of Health Behavior. 20(6):389-399, November-December 1996.

**Abstract:** The authors developed and implemented a health promotion program designed to reach older African Americans with health messages that could increase their awareness of the risk factors for disabling illness and increase their participation in health promotion activities. The authors targeted two Georgia areas with large, older, black populations. The authors conducted a needs assessment and developed the program into three major components: (1) a culturally sensitive health promotion training program designed to increase participation in outreach activities, (2) the use of the grassroots network to disseminate health education materials, and (3) the use of indigenous older adults as lay educators and health advocates. Program developers divided the content of the training curriculum into three general categories: (1)

chronic disease education and self care, (2) lifestyle education, and (3) consumer education. Category topics were developed into 12 training modules packaged in an instructor's guide. A second guide was developed for those participants who were trained as lay educators. The authors reviewed health promotion and education materials and conducted a pilot test to determine which guide the target population was most likely to use. Researchers recruited and trained members of the target population as lay health educators to promote the health education program. The health promotion training program was open to anyone over the age of 55 living in a target community. Program staff conducted a 12-week training program for each of the partnership organizations and evaluated the program using a brief registration form that was completed by each attendee. The program exceeded initial expectations, both in the extent and enthusiasm of response and in the program's ability to deliver an education program to a population previously considered hard to reach. 1 figure, 3 tables, 27 references. (HE9700462)

079

### **Neighbor to Neighbor: Community Health Workers Educate Their Own.**

**Form:** Journal article.

**Author:** Sherer, J.L.

**Source:** Hospitals and Health Networks. 68(20):52-54, 56, October 20, 1994.

**Abstract:** A health professional describes the efforts of community health workers (CHW's), who were serving as health promoters among residents in their respective communities that have traditionally lacked access to adequate health care. Sponsored by Planned Parenthood, the Promotoras Comunitarias program was one of many being established across the country. Promotoras hosted at least six in-home

presentations a year in which they taught local women about birth control, disease prevention, and the importance of regular breast examinations, mammographies, and Papanicolaou smears. Training from 20 to 120 hours was provided, depending on the program. CHW's were responsible for motivating and empowering community members to identify their own needs and implement their own solutions through advocacy, outreach, health and promotion, disease prevention, and professionally supervised direct care. Elements of a successful CHW program included established rapport with the community, assessment of community health needs at the project onset, multilingual and multicultural staff, shared ownership and decision-making, flexibility, and linkages to a referral system. (HE9700077)

080

### **Using Paraprofessionals in the Arkansas Health Education Programs.**

**Form:** Journal article.

**Authors:** Fox, E.L.; Lammers, J.W.; Deere, R.E.

**Source:** Health Education. 9(2):12-13, March-April 1978.

**Abstract:** Researchers studied the use of indigenous homemakers as community health education aides. The 120-hour aide training program focused on specific diseases, basic first aid, and basic home sanitation. Aides also received instruction in referring clients to appropriate resources in the local health delivery system. The aide taught the homemaker one preprepared mini-lesson on (1) the effects of living habits on health; (2) the use of preventive health practices; (3) when to practice self-care as opposed to resorting to professional care; (4) the effects of a clean home environment on health; and (5)

understanding of the local health care delivery system. Program assessment, as measured by a participant a family review form, showed significant improvement in all categories of health knowledge and maintenance behavior, except dental care and weight loss. (HE7900635)

community self reliance. 4 figures, 16 references. (HE9100636)

081

### **Women's Health Perspective in Primary Health Care: A Nursing and Community Health Worker Demonstration Project in Urban America.**

**Form:** Journal article.

**Authors:** Swider, S.M.; McElmurry, B.J.

**Source:** Family and Community Health. 13(3):1-17, November 1990.

**Abstract:** The Primary Health Care in Urban Communities demonstration project trained community residents as community health workers to work in two low-income communities in Chicago, Illinois. One community was primarily black, with a large concentration of families in poverty, living in public housing, and with female single heads of household; the other was a low-income, multiethnic community in which most residents were Hispanic, primarily Mexican-American. The PHCUC project, developed by the Women's Health Group at the College of Nursing, University of Illinois at Chicago (UIC), aimed to implement the primary health strategy in two neighborhoods by training local women as community health workers in these communities. The perspective at UIC on women's health focused on learning about multiple aspects of women's life experiences: historical, political, cultural, developmental, and socioeconomic. The project worked with women in the community to help them address community health concerns; the emphasis was on collaboration, essential health services, and



# Chronic Diseases and Risk Factors

## Asthma

082

### **Targeting High-Risk Groups: Neighborhood Organization for Pediatric Asthma Management in the Neighborhood Asthma Coalition.**

**Form:** Journal article.

**Authors:** Fisher, E.B.; Sussman, L.K.;  
Arfken, C.; Harrison, D.; Munro, J.;  
Sykes, R.K.; Sylvia, S.; Strunk, R.C.

**Source:** Chest. 106(4, Supplement):248S-  
259S, October 1994.

**Abstract:** The Neighborhood Asthma Coalition offered a community organization approach to promoting basic understanding of asthma and encouraging improved care in four low-income, predominantly African American, neighborhoods of St. Louis, Missouri. The Neighborhood Asthma Coalition emphasized neighborhood and community organization strategies and social support to reach asthmatic children, their parents or caretakers, and other family and friends. The Neighborhood Asthma Coalition activities included (1) promotional campaigns to increase awareness of asthma and its care and to recruit participants into coalition programs; (2) neighborhood residents trained as CASS (changing asthma through social support) workers to work with asthmatic children and their caregivers to encourage asthma management and to conduct management programs in local institutions; (3) a neighborhood summer day camp and year-round neighborhood asthma activities for asthmatic children, their families, and friends; (4) an asthma management curriculum offered through the camp and neighborhood activities, and through community health centers and churches; and (5) plans for activities in

neighborhood schools. The Neighborhood Asthma Coalition operated in the target neighborhoods also served by Grace Hill Neighborhood Services, an affiliation of eight settlement houses, a housing corporation, and several health centers. CASS workers developed a yearly calendar that included hints and reminders on asthma management and listings of medical providers, pharmacies, sources of aid for medical care and medication, and other sources of services and support. The coalition produced *In Our Own Words*, composed of the statements of summer campers regarding their feelings about asthma and new perspectives gained through camp. Open Airways, the American Lung Association's curriculum for school-based asthma management programs, was reviewed and adapted for use in coalition activities. In addition to appropriate evaluation surveys of the community and schools, evaluation centers on a controlled, cohort study of neighborhood children compared with children from comparable neighborhoods. The authors conclude that the Neighborhood Asthma Coalition illustrates the potential of community organization approaches to involve neighborhood residents in planning and implementing programs for asthma education and management. 1 figure, 4 tables, 41 references. (HE9600949)



# Chronic Diseases and Risk Factors

## Cancer

083

### **Breast and Cervical Cancer Project in a Native Hawaiian Community: Wai'anae Cancer Research Project.**

**Form:** Journal article.

**Authors:** Banner, R.O.; DeCambra, H.; Enos, R.; Gotay, C.; Hammond, O.W.; Hedlund, N.; Issell, B.F.; Matsunaga, D.S.; Tsark, J.A.

**Source:** Preventive Medicine. 24(5):447-453, September 1995.

**Abstract:** Researchers presented preliminary findings from the first year of the Wai'anae Cancer Research Project, a community intervention to increase breast and cervical cancer screening practices among native Hawaiian women. Researchers conducted a baseline telephone survey to obtain an initial assessment of community knowledge, attitudes, and behaviors related to cancer among women in the intervention community and in a control community. Women from the community conducted the interviews, using interview protocols similar to the Behavioral Risk Factor Survey Study (BRFSS) of the Centers for Disease Control and Prevention (CDC), which were modified to reflect culturally appropriate techniques. The sample included 1,260 women, ages 18 to 60 years, drawn equally from the study and control communities. This sample size allowed for the detection of a 10 percent increase in adherence to cancer screening guidelines. The primary intervention involved the formation of health-activated support groups, called Kokua Groups, within existing Hawaiian social networks. Volunteer peer leaders recruited the groups, and outreach educators facilitated them. The support groups sought to change the behavior of women not

currently receiving cancer screening. Survey respondents were relatively evenly distributed across age groups, with almost 50 percent under age 40. Although only 52 percent of respondents knew about the Papanicolaou (Pap) test, 94 percent reported having received at least one Pap test. Eighty percent reported practicing breast self-examination at least periodically, and 80 percent reported having obtained a clinical breast examination during the past 2 years. Of the women over age 40, 71 percent reported having had at least one mammogram in the past, and 59 percent reported having had a mammogram during the past 2 years. Thirty-six percent of the women stated that they had encouraged others to obtain breast cancer screening. Twenty-eight percent reported having used native Hawaiian medical remedies during the past year. Results indicate that a majority of the participants took part in cancer detection and screening activities. A significant minority, however, did not participate in cancer screening. 2 tables, 16 references.

(CP9600102)

084

### **Community-Level Cancer Control in a Texas Barrio: Part I, Theoretical Basis, Implementation, and Process Evaluation.**

**Form:** Journal article.

**Authors:** Ramirez, A.G.; McAlister, A.; Gallion, K.J.; Ramirez, V.; Garza, I.R.; Stamm, K.; de la Torre, J.; Chalela, P.

**Source:** Journal of the National Cancer Institute Monographs. 18:117-122, 1995.

**Abstract:** Researchers designed and implemented Programa A Su Salud, a theory-based program that used peer modeling and a



network of peer communicators to promote breast and cervical cancer screening in a barrio of San Antonio, Texas, with a population of approximately 25,000 women. The main objectives of the program were to increase screening and compliance with Papanicolaou smear test recommendations among Mexican American women over age 17, and to increase screening and compliance with mammography recommendations among Mexican American women over age 39. The program combined mass media and community activities in its peer-based approach. The program used several forms of mass media, including print, radio, and television in both English and Spanish formats to present role models. Role models were recruited from the community and each reflected the same socioeconomic, ethnic, and cultural characteristics as the targeted audience. Results of a program evaluation showed that approximately 84,000 pieces of program material were disseminated over 2 years. An average of 5.7 stories were published per month about the program, with the majority appearing in newspapers. A total of 85 volunteers were recruited to participate in the program; 92 percent were female, average education was seventh to eighth grade, and average age was 49. Each of the volunteers helped an average of 12 of their peers to make screening appointments, and an average of 6 were followed by the volunteer to make sure the appointment was kept. 5 tables, 24 references. (CP9500588)

085

### **Effect of a Cancer Screening Intervention Conducted by Lay Health Workers Among Inner-City Women.**

**Form:** Journal article.

**Authors:** Sung, J.; Blumenthal, D.S.; Coates, R.J.; Williams, J.E.; Alema-Mensah, E.; Liff, J.M.

**Source:** American Journal of Preventive Medicine. 13(1):51-57, January-February 1997.

**Abstract:** The authors conducted a trial to determine if an in-home, culturally sensitive educational intervention conducted by lay health workers (LHW's) could increase adherence among low-income, inner-city, African American women to breast and cervical cancer screening schedules. The LHW's were recruited from the National Black Women's Health Project (NBWHP), a self-help health organization for African American women. The LHW's trained for 10 weeks in interviewing and health education topics before the intervention and then interviewed 321 women, using a standardized questionnaire. The women were recruited from the patient registry of an inner-city community health center; from personal contacts in public housing projects, business establishments, and churches; and through referrals from the NBWHP. The questionnaire assessed past history of cervical and breast cancer screening and knowledge and attitudes toward cancer and cancer prevention. Participants were then randomly assigned to intervention and control groups. LHW's visited the intervention group participants in their homes two times, 1 month apart, and scheduled a booster session for 2 months after the second session. The sessions focused on breast and cervical cancer, cancer screening procedures, reproductive health, and high-risk sexual practices. The intervention also included a

videotape of an African American woman receiving a Papanicolaou (Pap) test and breast self-examination from an African American physician. The LHW's conducted follow-up interviews, with the intervention and control groups 6 months after the intervention. In both baseline and follow-up interviews, participants were asked when they had last received cancer screening exams. The control group received educational materials on cancer screening after the completion of the follow-up interview. Results showed the increase in screening for Pap tests was similar in both the control and intervention groups. There was a small increase in clinical breast examinations in the intervention group, with the greatest increase being for mammography. Among women who were not on recommended breast and cervical cancer screening schedules at baseline, the scheduling improvement was substantial and greater in the intervention group. The use of LHW's in the project contributed to the increase in breast cancer screening for the intervention group. The researchers also discussed the potential for using LHW's and the difficulties of providing health education and promotion to low-income, inner-city residents. 4 tables, 25 references. (CP9700266)

086

**Intervention to Increase Breast and Cervical Cancer Screening in Low-Income African American Women.**

**Form:** Journal article.

**Authors:** Whitman, S.; Lacey, L.; Ansell, D.; Dell, J.; Chen, E.; Phillips, C.W.

**Source:** Family and Community Health. 17(1):56-63, April 1994.

**Abstract:** Researchers evaluated an intervention to increase breast cancer and cervical cancer screening in low-income, African American women living in Chicago,

Illinois. The intervention, conducted from June 1989 to November 1990, was implemented by nurses and outreach workers who were chosen based on their level of cultural sensitivity and familiarity within the community. At a neighborhood center, the intervention program presented a class on breast and cervical cancer and an invitation to screening. Another Department of Health center served as a control site. Nurses recruited women who expressed an interest in participating in the program; outreach occurred in many institutions in the community, including churches, beauty shops, laundromats, libraries, and grocery stores. The primary outcome measure used to evaluate the intervention was the proportion of eligible women who received screening examinations in the 12 months prior to data collection. Data were abstracted from medical records for the women who had made an appointment or walked in and were seen during the clinic session. The proportion of women who received Papanicolaou (Pap) smears rose from 12 percent at baseline to 26 percent at 12 months postintervention, the proportion receiving clinical breast examination rose from 6 percent to 18 percent, and the proportion receiving mammograms rose from 3 percent to 11 percent. Screening proportions decreased in the control group. 2 tables, 27 references. (CP9400388)



087

### **Lay Health Advisors: A Strategy for Getting the Word Out About Breast Cancer.**

**Form:** Journal article.

**Authors:** Earp, J.; Viadro, C.I.; Vincus, A.A.; Altpeter, M.; Flax, V.; Mayne, L.; Eng, E.

**Source:** Health Education and Behavior. 24(4):432-451, August 1997.

**Abstract:** The North Carolina Breast Cancer Screening Program used a lay health advisor (LHA) intervention designed to increase the use of mammography screening services by African American women over age 50 years who resided in five rural eastern North Carolina counties. Five local African American women were hired as specialists to conduct community assessments, recruit natural helpers and train them as LHA's, coordinate LHA activities, and create and work with five county community advisory groups. Then 125 women from the target communities were trained to serve as LHA's. Researchers developed a separate training manual for each county to reflect the unique concerns of the women in each county and to provide county-specific descriptions of mammography services. The LHA's designed and conducted a variety of outreach activities in such settings as African American churches, beauty parlors, supermarkets, and family reunions. LHA activities (1) provided education about breast cancer screening; (2) facilitated access to mammography facilities by providing transportation, accompanying a woman to the screening, and disseminating information about available services; and (3) addressed health system barriers by organizing special screening days or raising funds for women who could not afford mammograms. Multiple strategies were used to evaluate the LHA's profile, training, activities, and effect on breast cancer screening behaviors of the target

population. The primary challenges faced by the program during implementation related to acquisition of resources, identification and recruitment of committed LHA's, support for the LHA activities, evaluation methodology, and the need for a multilevel intervention approach that extended beyond the LHA's social network focus. 2 tables, 44 references. (CP9700551)

088

### **Natural Helping Functions of Lay Health Advisors in Breast Cancer Education.**

**Form:** Journal article.

**Authors:** Eng, E.; Smith, J.

**Source:** Breast Cancer Research and Treatment. 35(1):23-29, 1995.

**Abstract:** The Save Our Sisters (SOS) Project used the skills of 95 individuals called "natural helpers" to increase mammography screening among older black women in a North Carolina county. Natural helpers are lay people to whom others naturally turn for advice, emotional support, and tangible aid. To identify and recruit natural helpers, the SOS project hired as SOS Project Coordinator a retired black woman from a black community who was socially active in a range of local groups and associations. She formed a 12-member community advisory group with contacts to other community groups; this advisory group organized 14 focus group interviews with members of different community organizations and reviewed the findings. Interview results were used to develop the learning objectives for a Peace of Mind training course for lay health advisors (LHA's) and to describe the characteristics of natural helpers to whom older women turn with female concerns. A total of 125 potential LHA's were identified and 24 completed the first training course. Findings from the focus groups showed that older



women do seek out natural helpers to discuss their personal concerns before they consult professionals. Through the SOS project, natural helpers provided a community-based system of care and social support that complemented the more specialized role of health professionals. The roles of the LHA's included (1) assisting people in their social networks with needs that are difficult for professionals to address, (2) negotiating with professionals for support from the health system, and (3) mobilizing the resources of associations in their community to sustain support from the health system. 2 tables, 17 references. (CP9500567)

089

### **Por La Vida Intervention Model for Cancer Prevention in Latinas.**

**Form:** Journal article.

**Authors:** Navarro, A.M.; Senn, K.L.; Kaplan, R.M.; McNicholas, L.; Campo, M.C.; Roppe, B.

**Source:** Journal of the National Cancer Institute Monographs. 18:137-145, 1995.

**Abstract:** Researchers describe the development and implementation of an intervention on cancer prevention for Latinas in San Diego, California. Thirty-six women from the Latino community were identified and recruited as *consejeras* on the basis of their leadership behaviors associated with the traditional role of helpers in the Latino community. Subsequently, these *consejeras* were trained to conduct small-group educational sessions on a particular health topic. Upon completion of the training, the *consejeras* invited 512 low income Latinas who had low levels of acculturation and education to participate in the small-group educational sessions from among their naturally occurring social networks (e.g., friends, neighbors, and

family members). Half of the *consejeras* were randomly assigned to a control group in which they conducted a program called Community Living Skills; the remaining *consejeras* conducted *Por La Vida*, an intervention program for cancer education. Using culturally appropriate educational materials, the experimental group of *consejeras* conducted *Por La Vida* sessions based on empowerment strategies, social support, and social learning theory. The *Por La Vida* program consisted of 12 weekly group sessions conducted over a 3-month period, followed by two additional sessions. Topics included (1) Introduction; (2) The Fountain of My Life; (3) The Feminine Body; (4) Where Cancer Can be Found; (5) Keeping Your Uterus and Cervix Healthy; (6) Keeping Your Breasts Healthy; (7) Overcoming Barriers; (8) Eat Well to Live Well; (9) Protect Your Health, Know Your Market; (10) Dangers of Smoking; (11) Moving Ahead; and (12) Graduation. Using pre-and posttests, the researchers found that in the cancer prevention groups, Latinas over age 40 years who had ever had a mammogram increased from 51.8 percent to 64.3 percent, while there was no statistically significant increase in the control group. There was no statistically significant change for Latinas over age 18 years who ever had a Papanicolaou (Pap) test in the control group, but in the intervention group the tested rate increased from 80.4 percent to 93.5 percent. Preliminary evidence suggests that the *Por La Vida* intervention may lead to significant increases in the rates of cancer screening test use and Pap test use. 8 tables, 42 references. (CP9500591)

090

### **Reach to Recovery Program.**

**Form:** Journal article.

**Author:** Rinehart, M.E.

**Source:** Cancer. 74(1, Supplement):372-375, July 1, 1994.

**Abstract:** Reach to Recovery is a peer modeling program provided by the American Cancer Society for women with a diagnosis of breast cancer. The program, designed to help women meet the physical, emotional, and cosmetic needs related to their disease and treatment, provides contact between women newly diagnosed with breast cancer and women who have been treated for the disease. Program volunteers must (1) have been treated for breast cancer; (2) have the approval of their physicians to participate; (3) maintain confidentiality; (4) have adjusted to their diagnosis and be emotionally stable; (5) show warmth, courtesy, tact, and consideration during a visit; (6) be knowledgeable of professional ethics; and (7) agree to participate in yearly training updates. Potential volunteers participate in a screening interview, and if accepted, they participate in a training session. Each new volunteer accompanies a trained volunteer on a visit before going on a visit alone. The volunteer provides the woman who has breast cancer with practical information, emotional support, and a temporary prosthesis. The information includes written materials from the American Cancer Society about different types of breast cancer treatment, breast cancer copying techniques, breast reconstruction, and appropriate exercises. One follow-up phone call is made to the woman, usually within 2 weeks of the visit. The volunteer usually provides the woman's physician with a visit report and sends a written report to the local cancer society office. The woman's physician must refer her to the program, although referrals can be initiated by

the nurse or social worker, and patients can refer themselves to the program. 1 figure, 2 references. (HE9700091)

091

### **Save Our Sisters Project: A Social Network Strategy for Reaching Rural Black Women.**

**Form:** Journal article.

**Author:** Eng, E.

**Source:** Cancer. 72(3):1071-1077, Supplement to August 1, 1993.

**Abstract:** The Save Our Sisters (SOS) Project, a pilot demonstration study in a rural North Carolina county, addressed breast cancer screening in older black women in an effort to help more older black women receive mammography screening. The target population was 2,600 black women ages 50 to 74 living in the county. To help these women obtain annual mammograms, SOS recruited and trained 64 black women to serve as lay health advisors. These advisors reached older black women through relatives, friends, and job networks. Responses from 14 focus group interviews found that, for older black women's health concerns, women turn to certain women for social support. Program planners evaluated focus group results and applied them to the Social Change model to design the health advisor training program. The program used three network intervention strategies: (1) providing social support (information and referrals, emotional caring, and tangible assistance) through interpersonal counseling with women in their social networks; (2) working as a group by planning and implementing breast cancer control and prevention activities through community organizations to which advisors belong (e.g., church, civic, and social groups); and (3) establishing the participants as a nonprofit,



community SOS Association to sustain project interventions after the funding period. The SOS Community Advisory Group and the advisors developed innovative methods of recruitment, implementation, and follow up. Community programs initiated include (1) the Adopt-A-Sister Program, which assists black women who cannot afford the cost of a mammogram; (2) a committee on understanding the health care system, which helps women negotiate regulations and use of health care providers; (3) a training committee, which recruits and trains additional advisors; (4) a support group for black women with diagnoses of breast cancer; and (5) a speakers bureau, which has produced a 10-minute videotape, brochure, and tee-shirts as community education materials. 3 figures, 5 tables, 8 references. (CP9300519)

092

### **Tailoring Lay Health Worker Interventions for Diverse Cultures: Lessons Learned From Vietnamese and Latina Communities.**

**Form:** Journal article.

**Authors:** Bird, J.A.; Otero-Sabogal, R.; Ha, N.; McPhee, S.J.

**Source:** Health Education Quarterly.

23(Supplement):S105-S122, December 1996.

**Abstract:** The authors discuss two interventions in which indigenous lay health workers promoted the early detection of breast and cervical cancer in selected Vietnamese and Hispanic community members in San Francisco, California. The Vietnamese program is called *Suc Khoe La Vang!* (Health is Gold!); the Hispanic program is called *En Accion Contra El Cancer* (In Action Against Cancer). The interventions were developed and conducted as part of a National Cancer Institute program project, *Pathways To Early Cancer Detection in Four Ethnic Groups*. The

Vietnamese project's design included recruitment of 10 indigenous lay health workers, to be known as neighborhood leaders (NL's), and 30 neighborhood leader assistants (NLA's). Each NL was to conduct 24 prevention and early detection educational events for women in her community (6 on general prevention, 9 on cervical cancer, and 9 on breast cancer). The NLA's recruited hostesses, recorded the events, and administered a brief participant survey. By the end of the first year of the project, 9 active and 2 inactive NL's and 22 active NLA's had been recruited. By the end of the second full year, of the 15 NL's who had been trained, 9 were still active; 60 NLA's had been recruited, and 24 remained active. The program planners found that the Vietnamese women were reluctant to invite participants to share social activities in their homes, because scheduled social gatherings in Vietnamese culture tend to occur around special religious or family events. However, once at the presentations, most women said they were glad they had attended. Cash incentives to hostesses and participants were effective in recruitment, since most of the targeted women lived below the poverty line. The Hispanic project included both multimedia and interpersonal interventions. The NLA's were used as role models in the former, and peer networkers and promoters in the latter. The NLA's presented testimonials on local Spanish-language media to stimulate and reinforce positive behavior changes and attitudes about early cancer prevention and detection. Peer networkers and promoters were expected to participate in community events and disseminate information. The peer networkers and promoters received small incentive stipends. During the first 9 months of the project, 147 networkers, 68 promoters, and 140 role models were recruited. In contrast with the Vietnamese NLA's, the Hispanic NLA's accomplished their work in the context of



diverse social networks. Family-like relationships developed among and between the staff and participating women. The authors conclude that the NLA's were effective change agents and filled a unique and essential function as mediators between the professional staff and the community. 67 references. (CP9700116)

093

### **Urban Church and Cancer Control: A Source of Social Influence in Minority Communities.**

**Form:** Journal article.

**Authors:** Davis, D.T.; Bustamante, A.; Brown, C.P.; Wolde-Tsadik, G.; Savage, E.W.; Cheng, X.; Howland, L.

**Source:** Public Health Reports. 109(4):500-506, July-August 1994.

**Abstract:** Researchers examined the efficiency of a church-based model of social influence in improving access to, and participation of, underserved minority women in a cervical cancer control program. To participate in the study, researchers selected 24 churches, stratified by faith tradition, from Los Angeles, California. These churches had responded to a letter offering an opportunity to participate in Drew University's cervical cancer control program. Approximately 30 to 150 women from each church were eligible to participate in the study. Pastoral commitment to the church role in the program was secured and a lay health leader from each congregation was selected. Clergy from the 24 churches selected a total of 30 lay health leaders; of these, 97 percent participated in two training sessions. The program consisted of two primary components: education and screening. A total of 1,012 women aged 21 to 89 attended educational sessions on cervical cancer as part of the program, and lay health leaders targeted 44 percent of these women for screening

because they either had not had a Papanicolaou (Pap) smear test within the past 2 years or had never been screened. Black women were 6.6 times more likely than Hispanics to have been screened in the past 2 years. Hispanic women were 4.2 times more likely than African Americans never to have had a Pap test or to have not been tested in 3 or more years. Most of the women screened were between ages 21 and 39. A total of 52 percent of the churches continued the cancer prevention campaign for at least 2 years following the end of the program period. 4 tables, 13 references. (CP9500437)

094

### **Women's Wellness Sourcebook: Module II: Cancer.**

**Form:** Teaching guide.

**Authors:** Jackson, T. ed.; Lasco, M.L. ed.; Calley, S.; Henning, M.; Linton, K.; Loosli, M.; Tamasabi, S.; Rivett, S.

**Source:** Sterling, VA, INMED, 104 pages, 1997.

**Abstract:** Women's Wellness Sourcebook: Module II: Cancer is the second in a series of six modules designed for trainers of health advisors. The adaptable curriculum in each module can be used independently or in combination with other modules. The training is based on the shared learning experience model, requiring the active involvement and participation of trainees. The training activities help participants identify their strengths, share their experiences, and combine efforts to create an effective community health program. Each unit in the module contains an overview, objectives, timetable, an outline of the topics covered, a list of materials needed, information on advance preparation needed, and the trainer's notes. The trainer's notes contain guidance to each activity, points to emphasize, training tips and techniques, and summary suggestions.

This second module was intended to teach health advisors about cancer, and enable them to support women in their community who have been diagnosed with cancer. The five units provide an overview of cancer, and details of breast, reproductive, lung and colon cancer. The overview discusses how cancer develops, the types of cancer, risk reduction, screening, treatment options, support, and coping. Each of the four types of cancer is discussed by definition, risk, protection, and treatment. The importance of regular screening and healthy lifestyle habits is emphasized. The topic of supporting women who have been diagnosed with cancer is also addressed. (HE9800123)





# Chronic Diseases and Risk Factors

## Cardiovascular Disease

095

### **Community Health Representatives: A Valuable Resource for Providing Coronary Heart Disease Health Education Activities for Native Americans.**

**Form:** Journal article.

**Authors:** Cleaver, V.L.; Ratcliff, R.; Rogers, B.

**Source:** Health Education. 20(6):16-31, October/November 1989.

**Abstract:** This historical overview focused on the lifestyle and coronary heart disease (CHD) health status of Native Americans. Heart disease is the leading cause of death among Native Americans. The Community Health Representative (CHR) was a paraprofessional within the Native American community who provided health care, health promotion, and disease prevention services. The community health representative program staff selected persons with basic health and medical skills and trained them as outreach workers in their respective communities. The Indian Health Service (IHS) improved the abilities of these paraprofessionals as health educators to more effectively coordinate CHD primary prevention activities in their respective communities within Oklahoma. A cardiovascular disease risk assessment and education program conducted at a CHR conference had two primary objectives: (1) to favorably influence the CHR's attitude toward screening and cardiovascular health education, and (2) to help CHR's understand the long-term beneficial implications to such programs. Sixty-seven CHR's completed all testing and the educational follow up. CHR's were categorized by their relative risk for developing CHD. The majority of CHR's had a

relatively high risk for CHD for each of the risk factors. 1 table, 18 references. (HE9000232)

096

### **Community Health Worker: A Resource for Improved Health Care Delivery.**

**Form:** Journal article.

**Authors:** Richter, R.W.; Bengen, B.;

Alsup, P.A.; Bruun, B.; Kilcoyne, M.M.; Challenor, B.D.

**Source:** American Journal of Public Health. 64(11):1056-1061, November 1974.

**Abstract:** The Community Health Worker Training Program represented a major component of the Harlem (New York) Region Stroke Program, established in 1970 to screen for, treat, and follow up persons with hypertension, stroke, and related diseases. The training program was designed to create a new entry-level health position for inner-city residents who show potential for contributing to health care delivery but who have not been able to use their abilities within a traditional health structure. Twenty-one trainees were chosen for the first 6-month training program, which integrated didactic and clinical teaching, emphasizing pathogenesis and treatment of stroke, hypertension, and related diseases. Most of the trainees had completed high school, had reading levels of 10th grade and above, and had scores of 9th grade or above in problem-solving and math skills; most had little previous exposure to the health field; a large percentage had records of past social, personal, or family problems. Fourteen trainees successfully completed the 6-month program and were placed in health worker positions in specialties such as hypertension unit assistant and stroke

unit follow-up workers, social service casework assistant, and EEG technician trainee. The authors conclude that training programs and job roles for community health workers need to be legitimized and standardized to overcome present fragmentation of programs and to ensure career mobility among allied health workers. Academic accreditation of training programs and their sponsorship by municipal, regional, or statewide health agencies are two critical prerequisites for these goals. 1 table, 18 references. (HE9401207)

097

### **Emergency Department Detection and Follow-Up of High Blood Pressure.**

**Form:** Journal article.

**Authors:** Bone, L.R.; Mamon, J.; Levine, D.M.; Walrath, J.M.; Nanda, J.; Gurley, H.; Noji, E.K.; Ward, E.

**Source:** American Journal of Emergency Medicine. 7(1):16-20, January 1989.

**Abstract:** Increasing numbers of people live in medically underserved urban areas and use hospital emergency departments (ED's) for their medical care. The ED's are reexamining their role to be more responsive to the health-care problems of the populations they serve. In a study conducted at the Adult Emergency Department of The Johns Hopkins Hospital over a 2-year period, chronic high blood pressure was used to measure the expanded role of the ED because of its prevalence and cost to poor urban communities. Community health workers provided three services to supplement health providers' routine efforts in high blood pressure detection, treatment, and follow up: (1) blood pressure and pulse measurements and risk reduction counseling; (2) telephone preappointment reminders; and (3) recontact of patients failing to show for their ED follow up visits. Researchers indicate that community

health workers are a useful resource for enhancing detection, referral, and follow-up of high blood pressure. These paraprofessionals can improve appointment keeping and can be useful in assisting in screening and counseling for chronic conditions within the ED. 1 figure, 21 references. (HE9000013)

098

### **Example of a Community Model for Comprehensive Stroke Services: The Harlem Regional Stroke Program.**

**Form:** Journal article.

**Authors:** Richter, R.W.; Bengen, B.; Bruun, B.; Kilcoyne, M.; Alsup, P.A.; Shafer, S.Q.; Brown, R.H.; Brust, J.; Dorset, V.E.

**Source:** Stroke. 5(1):135-144, January-February 1974.

**Abstract:** In response to the particularly high prevalence of stroke and hypertension among predominantly black populations, health professionals and community leaders established the Harlem Regional Stroke Program in 1970 to develop a model that might be replicated widely and raise awareness of the importance of broad-scale health maintenance and early detection of hypertension and stroke. The program established comprehensive services for the care of those with stroke and prestroke conditions and served as a unifying force in regional health care by bringing about a close working relationship among diverse health professionals and community members. Program goals included (1) interdisciplinary collaboration among providers and consumers, (2) creation of a stroke unit, (3) stroke prevention through community outreach and education, and (4) community health worker training program. Stroke program patients were admitted primarily through Harlem Hospital's emergency room and, once the diagnosis of stroke was confirmed, were enrolled in the



Stroke Program through the Neurology Consultation Service. From the time of admission and continuing up to 3 years after discharge, the patient's neurological and functional status was evaluated according to the protocol. The Community Outreach component of the Stroke Program, initiated in 1971, implemented a screening program to detect the community's high-risk population for hypertension and stroke and a public health education program to increase the community's acceptance and follow up to early detection and prevention efforts. A registered nurse and several full-time community health workers trained specifically for the program manage the community outreach portion of the program. The most important medical principle of the Stroke Program has been that to make a permanent impact in the reduction of morbidity and mortality, a program must include carefully planned systems of risk factor treatment and long-term follow up. 4 figures, 1 table, 9 references. (HE9700319)

099

### **Guidelines for African American Church-Based Health Promotion.**

**Form:** Manual.

**Corporate Author:** South Carolina Department of Health and Environmental Control.

**Source:** Columbia, SC, South Carolina Department of Health and Environmental Control, 37 p., n.d.

**Abstract:** The Center for Health Promotion and the Office of Minority Health of the South Carolina Department of Health and Environmental Control developed Guidelines for African American Church-Based Health Promotion as the second of a two-part publication on health promotion and the African American church or place of worship. The

manual was developed to support church efforts to improve the health status of the members of their congregations and to provide suggested strategies for dealing with specific health concerns that affect the African American population. Designed to be used by a committee or team of church members, the manual seeks to (1) increase the community's awareness of health needs and address possible solutions to health problems, (2) identify health needs of the congregation and interest in changing health-related behavior, (3) plan a careful strategy to improve the health of the congregation, (4) measure results, and (5) provide information and assistance in identifying and using local health resources. The first chapter of the manual gives an overview of the health status of African Americans and asserts that efforts within church-based programs could help to improve the health of African-Americans. Section 1 addresses (1) getting organized, (2) getting started, (3) designing the program, (4) starting the program, and (5) evaluating the program. Section 2 includes a discussion of stroke and hypertension. South Carolina has the nation's highest death rate from stroke, and the disease claims twice as many lives of African Americans than any other race. This manual suggests developing a program targeting stroke prevention in an effort to reduce these statistics. The appendix offers an example of a needs and interest survey, an example of a program interest questionnaire, and a detailed list of monthly health observances. (HE9700616)



100

### **Impact of a Planned Health Education Approach on the Control of Hypertension in a High-Risk Population.**

**Form:** Journal article.

**Authors:** Levine, D.M.; Bone, L.

**Source:** Journal of Human Hypertension. 4(4):317-321, August 1990.

**Abstract:** Researchers investigated the effects of disseminating a planned educational approach, found to be successful in a defined patient population, to an East Baltimore community of 80,000 persons with the demonstrated highest risk of uncontrolled hypertension and premature morbidity and mortality from this risk factor in Maryland. The educational-behavioral model used for planning, intervention, and evaluation is developed from educational and behavioral therapy and from the concepts of active participation and learning, behavioral reinforcement, self-efficacy, and social support. The program consisted of an exit interview reinforcing and clarifying treatment recommendations, a family education and support component, and small-group sessions to enhance patient activation and motivation. The program was evaluated by a randomized control trial in 400 patients. The experience, methodology, and approach of this phase was then applied to a population level. The population selected was from a low-income community that was primarily black (95 percent). The majority of families were on medical assistance and had an average educational level of 10 years of formal schooling. Within this population, the program focused on males aged 18 to 49 years. The program, directed and coordinated by a Community Provider Task Force, consisted of a combination of targeted screenings, outreach, and follow-up strategies to improve

identification of individuals with hypertension, enhance entrance into and encourage continuity of care, decrease drop-out rates and bring those who had discontinued treatment back into care, and improve adherence to prescribed treatment and blood pressure control. The participation of community health workers (CHW's) was a central component of the program. The CHW's were persons with no previous health training but who were already involved in community services. The CHW's received training according to the American Heart Association guidelines to provide blood pressure screening, educational counseling, monitoring, follow up, and outreach services. Emphasis was given to individuals from the hospital emergency room, which provides a disproportionate amount of health care for all adults in East Baltimore. Community surveys have shown that the percentage of individuals with hypertension who were aware of their condition increased from 65 percent in 1978 to 80 percent in 1986, and more than 90 percent of the population had their blood pressure checked yearly. The percentage of persons receiving treatment increased from 45 percent to 66 percent, and those persons achieved adequate blood pressure control rose from 32 to 50 percent. The results indicated that this planned health education approach was successful in significantly improving the control of hypertension in a high-risk population. The use of CHW's is particularly relevant for high-risk groups, such as young black males, who are least likely to be in a health care system, be diagnosed, be receiving treatment, or be under control. The use of CHW's to provide both targeted screenings and enhanced referral and follow-up mechanisms is essential to enhancing diagnosis, treatment, and adequate control. The authors suggest further training of CHW's to address more specific risk factors such as obesity, diabetes, alcoholism, smoking, and lack of a

reinforcing support structure. 1 figure, 5 tables, 6 references. (HE9700063)

101

### **Improving Hypertension Detection and Referral in an Ambulatory Setting.**

**Form:** Journal article.

**Authors:** Gillum, R.F.; Solomon, H.S.; Kranz, P.; Boepple, P.; Creighton, M.

**Source:** Archives of Internal Medicine. 138(5):700-703, May 1978.

**Abstract:** Investigators evaluated the extent to which patient appointment keeping for follow-up care can be improved by a paraprofessional health aide, whether the aide's efforts can improve hypertension detection in ambulatory settings within an urban teaching hospital, and (3) whether such an intervention is cost effective. They also present the yield of treatable hypertension, based on initial diastolic blood pressure. A paraprofessional aide working in ambulatory clinics of an urban teaching hospital in Boston encouraged nurses to take and record patients' blood pressures and then contacted patients who had elevated blood pressures who were not referred for treatment by clinic staff or who did not return for follow up. Blood pressure recording by clinic staff increased during the intervention from 54 percent to 68 percent of patients. Appointment keeping increased with intervention from 13 to 73 percent of those eligible for referral. The yield of hypertensive patients initiating treatment management increased from a control level of 7 to 22 percent of total patients eligible for referral. The authors conclude that a relatively inexpensive and easy opportunity for screening large numbers of people in ambulatory clinics is being neglected. A health aide can be effective in improving detection and referral of hypertensive patients at low cost. 3 figures, 1 table, 12 references. (HE9700073)

102

### **Improving Referral Compliance After Public Cholesterol Screening.**

**Form:** Journal article.

**Authors:** Maiman, L.A.; Hildreth, N.G.; Cox, C.; Greenland, P.

**Source:** American Journal of Public Health. 82(6):804-809, June 1992.

**Abstract:** Researchers examined whether health professional counselors at cholesterol screening and follow-up interventions affect compliance with referral for retesting and diagnosis. Researchers also assessed the contributions of sociodemographic characteristics, coronary heart disease risk factors, and health motivations. At the screening, health professionals and lay communicators referred participants meeting age-specific criteria for moderate or high-risk cholesterol levels to a physician for retesting and diagnosis. Initially, each participant received counseling from a health professional or lay communicator; all individuals without a regular source of medical care received a list of primary care physicians who were accepting new patients. After each screening shift, researchers randomly assigned 2,109 participants to a coupon offer group, referral reminder letter group, or control group. Before receiving their test result, each participant completed a self-administered questionnaire at screening. Five months later, researchers conducted telephone interviews with 1,975 participants. The questionnaire and interview inquired about general health information, cholesterol-specific items, and the physician visit. Results showed that physician visit rates yielded no professional or lay differences. For patients with no medical history, the behavioral interventions were effective compared with controls (the coupon yielded 60.7 percent and the reminder letter yielded 57.7 percent



responses versus control response of 46.1 percent). With professional counseling, only the coupon was effective; for lay counseling, both coupon and reminder yielded higher visit rates. When adjustments were made for sociodemographics, heart disease risk factors, and health perceptions, the intervention effects remained. The results suggest that the influence of the behavioral interventions depends on cholesterol history and communicator type. For those with newly identified cholesterol elevations, both types of follow up yielded better physician visit rates than no follow up. 4 tables, 32 references. (HE9201240)

103

### **Narrowing the Gap in Health Status of Minority Populations: A Community-Academic Medical Center Partnership.**

**Form:** Journal article.

**Authors:** Levine, D.M.; Becker, D.M.; Bone, L.R.

**Source:** American Journal of Preventive Medicine. 8(5):319-323, September-October 1992.

**Abstract:** Program developers used six steps to develop a joint, community-based, coordinated program between a high-risk African American population in Baltimore, Maryland and Johns Hopkins University Medical Institutions. The steps were (1) selecting a target minority population; (2) developing a coordinated community and medical care system task force to direct the program; (3) assessing current patterns of preventable or controllable premature morbidity and mortality; (4) selecting specific health and behavioral priorities to address and goals to achieve; (5) designing intervention and evaluation methods, including intervention strategies that provide training and skill

building for the population served; and (6) planning for long-term effectiveness and sustainability based on the community-provider collaboration model. The program was based on a diagnostic, intervention, and evaluation model to influence behavioral change and enhance health status. There were three phases of the program: initial development (1974 to 1979), the second phase (1979 to 1987), and the third phase (1987 and beyond). The initial phase consisted of a highly successful patient-based intervention focusing on the care and control of hypertensive vascular disease in the community. This experience was then disseminated into a community-based public health program for the second phase. A key feature of the second phase was the training of community residents to provide outreach, linkage, and monitoring services, including screening and counseling for high blood pressure, weight control, and cessation of smoking and excessive alcohol consumption. Community health workers significantly improved identification and control of hypertension in the population; positive effects of the workers were enhanced linkage, continuity of care, and control of hypertension. The third phase of the program consisted of a church-based, multiple risk factor program entitled "Heart, Body and Soul," part of which focused specifically on smoking cessation. Church ministers and members were trained to lead small groups and to administer churchwide activities and health fairs. This community-based program has demonstrated significant effects in decreasing morbidity and mortality and in enhancing the health status of a high-risk urban African American population. (HE9300355)



104

### **Role of Community Volunteers in Health Interventions: A Hypertension Screening and Follow-Up Program.**

**Form:** Journal Article.

**Authors:** Cooke, C.J.; Meyers, A.

**Source:** American Journal of Public Health. 73(2):193-194, February 1983.

**Abstract:** The use of community volunteers in health screening programs was evaluated in a hypertension screening and follow-up program. Volunteers from a resident health committee in an apartment complex community carried out door-to-door blood pressure screening of residents. The results of that screening were compared with those from a community where a resident health committee conducted central-site screenings and with those of a community where nonresident researchers staffed a central screening site. Door-to-door screening by community volunteers was significantly more effective than the two central-site screening methods, which did not differ from each other. Follow-up measures increased the number of hypertensive persons who reported seeking treatment by 100 percent. The failure to find differences between the two central-site programs suggests that community organization did not contribute to screening effectiveness. A previous study that employed resident door-to-door screeners without prior community organizing screened fewer residents, suggesting an interaction between community organization and door-to-door screening. 3 references. (HE8300154)

105

### **Role of Parents and Older Peers in School-Based Cardiovascular Prevention Programs: Implications for Program Development.**

**Form:** Journal article.

**Authors:** Cohen, R.Y.; Felix, M.; Brownell, K.D.

**Source:** Health Education Quarterly. 16(2):245-253, Summer 1989.

**Abstract:** The authors compared the effectiveness of peer-led interventions for nutrition, blood pressure education, and smoking prevention with interventions led by classroom teachers. Before implementation of the intervention programs, students in grades 5-8 completed a comprehensive health survey. Their parents completed a telephone survey of the same information; data came from 1,051 households. The survey instruments asked about the children's health habits, such as smoking, exercise, dieting, and fast food consumption, and about family discussions of health-related topics. The authors recruited the 76 older peer leaders from the local high school, where a peer counseling program was already in place. All peer counselors participated in a 4-day training during the summer to learn general helping skills and the curriculum they would be teaching. Four or five older peer leaders each taught a class of approximately 30 students. Students in grade 5 participated in the nutrition program (233), those in grade 6 participated in the blood pressure program (325), and students in grade 7 participated in the smoking prevention program (328). Each of the peer-led interventions consisted of four 45-minute classroom sessions and focused on the influence of parents as role models. Activities included homework assignments that parents and children completed together, discussions by the children

about their parents' behavior, and risk factor information mailed to the parents. Students in the teacher-led intervention received identical information, although without the small group discussions and without the additional focus on parents. Analysis of preintervention and postintervention survey data indicated that both interventions successfully increased participants' behavior toward nutrition and blood pressure (measured 1 year after the interventions). The parent-child survey showed reasonable agreement between parents and children for reports of the child's exercise, diet, and fast food consumption, but poorer agreement for smoking and perceptions of family interaction. The authors conclude that the findings provide preliminary evidence that older peer-led programs for the adoption of healthy behaviors can be effective. 1 table, 20 references. (SA9600401)

106

### **Women's Wellness Sourcebook: Module III: Heart Disease and Stroke.**

**Form:** Teaching guide.

**Authors:** Jackson, T. ed.; Lasco, M.L. ed.; Calley, S.; Henning, M.; Linton, K.; Loosli, M.; Tamasabi, S.; Rivett, S.

**Source:** Sterling, VA, INMED, 94 pages, 1997.

**Abstract:** Women's Wellness Sourcebook: Module III: Heart Disease and Stroke is one of a series of six modules designed for trainers of Health Advisors. The adaptable curriculum in each module can be used independently or in combination with other modules. The training is based on the shared learning experience model, requiring the active involvement and participation of trainees. The training activities help participants identify their strengths, share their experiences, and combine efforts to create an effective community health program. Each unit in the module contains an overview,

objectives, a timetable, an outline of the topics covered, a list of materials needed, information on advance preparation needed, and the trainer's notes. The trainer's notes contain guidance to each activity, points to emphasize, training tips and techniques, and summary suggestions. This module introduces health advisors to the topics in four units. Unit 1 gives an introduction to heart disease, how the heart works, the symptoms of heart disease, and diagnosing heart disease. Unit 2 discusses protecting against heart disease by reducing the risk of heart disease, lowering the risk of high blood pressure, cholesterol, smoking, and physical activity. Coronary artery disease and heart attack is covered in Unit 3, including the topics of coronary artery disease, what a heart attack is, how to recognize a heart attack, what to do when you think you are having a heart attack, and support and coping. Unit 4 discusses the topic of stroke, including what a stroke is, minimizing risk factors for strokes, what happens at the hospital, and recovery after a stroke. A list of recommended resources is provided at the end of the module. (HE9800124)



# Chronic Diseases and Risk Factors

## Diabetes

107

### **Community-Based, Culturally Sensitive Education and Group-Support Intervention for Mexican Americans With NIDDM: A Pilot Study of Efficacy.**

**Form:** Journal article.

**Authors:** Brown, S.A.; Hanis, C.L.

**Source:** Diabetes Educator. 21(3):203-210, May-June 1995.

**Abstract:** Researchers conducted a pilot study, the Rio Grande Valley Diabetes Education Study, to determine the feasibility of providing a diabetes patient education and group support intervention directed by a Mexican American clinical nurse specialist, dietitian, and community worker. Five persons with diabetes were selected from a longitudinal study and asked to participate in the intervention. They were over age 35 years, had noninsulin dependent diabetes mellitus (NIDDM), had taken insulin for at least 1 year in the past, and were willing to participate in the 9-week intervention. Each participant identified a family member or close friend who would participate in the sessions as a support person. The weekly 2-hour educational sessions included instruction on nutrition, self blood-glucose monitoring, exercise, and other diabetes self-management topics. Group discussion was aided by the use of Spanish-language videotapes developed for a Mexican community. Other activities included visiting a local grocery store to learn to read and interpret food labels, food demonstrations based on Mexican American food preferences, and sharing of healthy recipes. The community lay worker led a support group session held after the completion of the educational portion of the

program. Data on demographic and outcome variables were collected at baseline, and outcome data were collected 3 months after the program ended. Relevant outcome variables included knowledge of diabetes, health behaviors, weight, and indexes of metabolic control such as fasting blood sugar and glycosylated hemoglobin. Researchers conducted comparisons of preintervention and postintervention measures, using the Wilcoxin signed-rank test. For all five participants, statistically significant improvements occurred in glycosylated hemoglobin levels, fasting blood sugar levels, and knowledge of diabetes self-management. Researchers advised that, because of the small sample size and other limitations, these data must be interpreted cautiously. However, researchers concluded that the study demonstrated the feasibility of providing an acceptable intervention in this Mexican American community. 4 tables, 29 references. (HE9600778)

108

### **Training Outreach Workers to Serve American Indian Elders With Visual Impairment and Diabetes.**

**Form:** Journal article.

**Author:** Orr, A.L.

**Source:** Journal of Visual Impairment and Blindness. 87(9):336-340, November 1993.

**Abstract:** The author discusses the training of outreach workers to serve American Indian elders with visual impairment and diabetes. The incidence of blindness and visual impairment resulting from diabetic retinopathy is higher among American Indians than in the overall population. Additionally, the number



and life expectancy of American Indian elders have increased consistently over the past 40 years, so that a larger portion of this population are living many more years as blind or visually impaired persons. These statistics, coupled with the data that indicate American Indians with disabilities are substantially underrepresented in state and federal rehabilitation service systems, shows the need for an innovative service delivery model. In an effort to improve access to services, the American Foundation for the Blind (AFB) proposed to train indigenous community outreach workers in the basics of independent living skills. Through funding from the Administration on Aging and in cooperation with the Indian Health Service (IHS), AFB developed and implemented a two-phase independent living skills training project entitled, A Training Model to Teach Community Outreach Workers to Train Elderly Blind and Visually Impaired American Indians Independent Living Skills: Focus on Family Rehabilitation. The project was conducted from 1987 to 1990 and was guided by a national advisory committee. During Phase I of the project, staff (1) developed a culturally sensitive model curriculum on aging and vision loss and training in independent living skills, (2) conducted 7-week sessions that trained a core of 250 community health representatives (CHR's), and (3) evaluated the training through follow-up surveys and visits to reservations. Phase II focused on preparing IHS to continue to use the model curriculum to train additional CHR's and to incorporate a core component of the curriculum into their basic training. The CHR's who specialized in work with the elderly or who had many elderly clients in their caseloads were given priority for training. Training sessions were located off the reservations in conference hotels and were conducted by AFB staff and local experts in the field of blindness. To determine the

effectiveness of the training, the AFB staff designed information gathering and assessment instruments. As a result of the project, training in independent living skills in the home has enhanced care to increase the maximum level of independent and interdependent functioning of older visually impaired American Indians. 2 tables, 17 references. (HE9700613)

109

### **Women's Wellness Sourcebook: Module IV: Diabetes.**

**Form:** Teaching guide.

**Authors:** Jackson, T. ed.; Lasco, M.L. ed.; Calley, S.; Henning, M.; Linton, K.; Loosli, M.; Tamasabi, S.; Rivett, S.

**Source:** Sterling, VA, INMED, 65 pages, 1997.

**Abstract:** Women's Wellness Sourcebook: Module IV: Diabetes is one of a series of six modules designed for trainers of health advisors. The adaptable curriculum in each module can be used independently or in combination with other modules. The training is based on the shared learning experience model, requiring the active involvement and participation of trainees. The training activities help participants identify their strengths, share their experiences, and combine efforts to create an effective community health program. Each unit in the module contains an overview, objectives, a timetable, an outline of the topics covered, a list of materials needed, information on advance preparation needed, and the trainer's notes. The trainer's notes contain guidance to each activity, points to emphasize, training tips and techniques, and summary suggestions. This module covers diabetes and supporting women with diabetes for health advisors. Unit 1 introduces diabetes and gives the definition, types of diabetes, and screening and diagnosis methods. Unit 2 discusses managing diabetes through the topics of monitoring blood sugar,

controlling blood sugar with insulin, healthy eating, exercise for healthy living, oral medication, and coping with diabetes. Unit 3 discusses short- and long-term complications of diabetes and sick-day management. A list of recommended resources is provided at the end of the module. (HE9800125)





# Chronic Diseases and Risk Factors

## Nutrition

110

### **Arizona Education Program Develops Indigenous Health Manpower.**

**Form:** Journal article.

**Authors:** Eichelberger, C.I.; White, M.; Braun, H.J.

**Source:** Journal of the American Dietetic Association. 71(2):143-146, August 1977.

**Abstract:** Health professionals in Arizona describe the Dietetic Education Program, a state program that aimed to provide optimal nutrition status in all communities by training community workers in public health nutrition. Although a demonstration project in 1970 resulted in the employment of 110 community nutrition/health workers throughout Arizona, the recent expansion of nutritional services meant a corresponding increase in staffing needs in rural areas and Indian reservations. To address this issue, a junior college agreed to provide academic training for these workers in conjunction with the Arizona Bureau of Nutrition Services. The program, the pilot phase of which began in January 1976 with 27 workers, was designed to achieve the following objectives within a 5-year period: (1) 100 workers will achieve greater proficiency, job satisfaction, and job mobility, (2) 50 workers will be trained for level II Community Nutrition positions, (3) 25 workers will be trained for advanced nutrition positions and for membership in the American Dietetic Association, (4) 5 workers will be prepared to qualify for admission to a B.S. degree program in nutrition, and (5) a career ladder position will be designed for community nutrition personnel. The personalized system of instruction allowed personal contact between the instructor and the

student in competency-based instructional materials (modules). Aides enrolled on a voluntary basis. Materials, the delivery system, staff development and use, and program administration and student performance was evaluated by Central Arizona College, the Arizona Department of Health Services, and an outside contractor. 2 tables, 9 references. (HE9700068)

111

### **Influence of a Nutrition Education Program (EFNEP) on Infant Nutrition in East Harlem.**

**Form:** Journal article.

**Authors:** Bowering, J.; Lowenberg, R.L.; Morrison, M.A.; Parker, S.L.; Tirado, N.

**Source:** Journal of the American Dietetic Association. 72(4):392-397, April 1978.

**Abstract:** The effectiveness of nutrition aide work with physicians, nurses, and nutritionists in the Expanded Food and Nutrition Education Program (EFNEP) in East Harlem, New York, was assessed in a study of infants from low-income families attending a hospital's well-baby clinic. The evaluation focused on three areas on which the aides' teaching roles centered: milk intake, variety of foods consumed, and anemia risk. The nutritionist obtained information on the infant's age in months when whole milk became part of the diet. From the information on a 24-hour dietary recall, taken from homemakers by aides, a variety score was computed on the basis of whether a particular food category was reported. Assessment of an individual infant's anemia risk was based on hemoglobin measurements from several clinic visits. A

control group of infants received no aide visits. Findings revealed that (1) a trend toward delaying the introduction of whole milk to infants in favor of formula was consistently observed in the study group; (2) more food categories were mentioned on recall by mothers of study group infants; and (3) 70 percent of study group infants were at low risk of anemia, as compared to 56 percent of control group infants. Findings demonstrate the benefits of reinforcing clinical well-baby care with one-to-one contact and advice by aides working in people's homes. 13 references. (HE7900046)

112

### **Weight Management Practices of Black Paraprofessional Women.**

**Form:** Journal article.

**Authors:** Reames, B.; Burnett, M.F.

**Source:** Journal of the American Dietetic Association. 91(7):841-843, July 1991.

**Abstract:** Researchers studied the effect of participation in a weight control workshop by black female paraprofessionals employed as Expanded Food and Nutrition Education Program (EFNEP) nutrition aides on selected indexes, including dietary intake, nutrition knowledge, exercise practices, eating behaviors, anthropometric measurements, and sick leave hours used. Approximately 19 black urban nutrition aides participated in the Healthy Weight Workshop, during which they received weight control information for personal and EFNEP participant use. Researchers recruited a second group of 18 black urban nutrition aides to participate as the control group. Researchers collected data from both groups 1 week before, 1 week after, and 6 months after the workshop. Researchers developed a Healthy Weight Workshop consisting of a series of six weight control sessions emphasizing lifestyle changes in diet (1,200-Kcal food group plan), exercise,

and eating behaviors. Researchers also developed four data collection instruments: (1) a nutrition knowledge instrument that included 25 true/false statements; (2) a dietary intake instrument that listed 39 food groupings for which respondents reported frequency of consumption; (3) an exercise practices instrument consisting of four statements scored on a 5-point scale; and (4) an eating behaviors instrument consisting of nine statements scored on a 5-point scale. The treatment group had significantly better dietary intake, nutrition knowledge, exercise practices, eating behaviors, weight, body mass index, and fewer sick leave hours used. Researchers noted no significant improvements for the control group. 1 table, 4 references. (HE9200281)

# Chronic Diseases and Risk Factors

## Tobacco Control

113

### **Heart, Body, and Soul: Impact of Church-Based Smoking Cessation Interventions on Readiness to Quit.**

**Form:** Journal article.

**Authors:** Voorhees, C.C.; Stillman, F.A.; Swank, R.T.; Heagerty, P.J.; Levine, D.M.; Becker, D.M.

**Source:** Preventive Medicine. 25(3):277-285, May-June 1996.

**Abstract:** Researchers determined the effect of an intensive, spiritually based church intervention on smoking behavior stages, compared with a minimal self-help strategy also administered in churches. The catchment area of the study represented 21 contiguous census tracts constituting East Baltimore and consisting of 71,291 residents. Of the 130 churches in the catchment area, researchers invited 23 to participate in the study. They randomly assigned churches to receive either an intensive, environmentally oriented, culturally specific intervention or an individual self-help intervention. Researchers obtained data on smoking status and stage of readiness from the congregation members at church health fairs held before and 1 year after initiation of the interventions. Multiple logistic regression results, controlling for intrachurch correlation and demographic and baseline smoking characteristics, showed that the multimodal cultural intervention group was more likely to make positive progress along the stages of change continuum, compared with the self-help intervention group. Church denomination and intervention status interacted in the multivariate model, with Baptists in the intensive intervention being three times more likely to

make progress than all the other denomination groups. The researchers conclude that the multimodal, culturally relevant intervention was more likely than a self-help intervention to positively influence smoking behavior. 2 figures, 4 tables, 25 references. (HE9600839)





# Issues of Aging

## Quality of Life

114

### **Friendly Visitor Program: Its Impact on the Social and Mental Functioning of the Elderly.**

**Form:** Journal article.

**Author:** Mulligan, M.A.

**Source:** Issues in Mental Health Nursing.  
1:1-11, Spring 1978.

**Abstract:** Over a 6-month period during 1971, the author evaluated the effect of the Friendly Visitor Program on behavior patterns regarding grooming and apartment upkeep (markers for social adjustment) of a small, nonrandom sample of isolated elderly people living on the Upper West Side of New York City. The Friendly Visitor program sought to reconnect the participants to others, give some indication of an awareness of their presence in the community, and show concern for their well-being. Six months after the visiting ended, the authors followed up to determine if there was any evidence of delayed deterioration in those receiving regular visiting as compared with those who were not visited regularly. The sample, consisting of 24 persons over age 64 years (median age 77.5 years), was divided into experimental and control groups. Participants in the experimental group received hour-long structured visits by one of five pairs of trained volunteer visitors every 2 weeks for 6 months. The same pair of visitors visited participants in the control group once in the beginning of the study and once at the end. An interview schedule, designed to assess the greeting behavior, grooming, apartment upkeep, cognitive awareness, and mental state of the visitee, was part of each visit. After each of the 12 visits to the experimental group and 2 to the

control group, the visitors gathered data on the appropriateness of the behavior of the visitees. Only on the first and last visits, when a pretest and posttest were administered, was any writing done in the presence of the visitees. Results show that none of the experimental group were either institutionalized or deceased upon follow up, while in the control group, three participants were in nursing homes and one was deceased. During the follow-up visit, the friendly visitor observed a significant improvement in the number of social contacts by the participants in the experimental group. There was steady improvement in grooming and apartment upkeep over the entire period for the experimental group; however, at the follow-up visit, there was a decrease in both grooming and apartment upkeep. It seemed that the termination of the program deprived the visitees of a motivating factor for caring about their appearance and living quarters. The findings showed that the mental state of the experimental group improved over the course of the visiting. The control group showed little change in apartment upkeep and a marked negative change in grooming. The researchers conclude that friendly visitor programs can be vital links between the isolated aged and community services available for their physical, mental, and social welfare. Also, with proper training for the friendly visitors, the program can become a crisis prevention measure and an alternative to institutionalization.

20 references. (HE9700346)

115

**Natural Helpers: Tools for Working With the Chronically Mentally Ill Elderly.**

**Form:** Journal article.

**Author:** Quam, J.K.

**Source:** *Gerontologist*. 24(6):564-567, December 1984.

**Abstract:** A professor at the School of Social Work at the University of Minnesota presents information about Sentinel House, program that served the needs of elderly patients with chronic schizophrenia and built on the concept of natural helping networks. In 1982, the Department of Public Welfare funded services to the chronically mentally ill persons living in board and lodging facilities. Sentinel House had as its key social support component natural helpers (i.e., friends, other residents, family members, neighbors, and anyone who served as part of an enduring support system and acted as a buffer against psychological problems). Sentinel House offered a combination of in-house services and linkage to existing community supports for 17 chronically mentally ill older adults aged 40 to 80 years. The program focused specifically on (1) independent living skills, (2) building of personal support through natural and devised networks, and (3) use of existing community resources and natural helpers. Network building was also carried out at the community level. Program ideas included (1) continuation of informal activities that already existed within the facility, (2) more formalized roles for natural leaders and opportunity for resident involvement, (3) more formalized roles for natural support systems outside the facility, (4) greater emphasis on natural supports as opposed to formalized services, (5) more staff activities gradually shifting to residents, (6) greater emphasis on activities that meet residents' developmental needs, and (7)

consideration of pets as natural helpers. The researcher conclude that programs for the elderly that seek to encourage a reality orientation and maintain relationships should consider the importance of using natural helping systems as therapeutic tools. 14 references. (HE9700081)

116

**Nutrition and Social Service Program for Older People: An Urban Model.**

**Form:** Journal article.

**Authors:** Gemple, N.; Hogue, J.

**Source:** *American Journal of Clinical Nutrition*. 26(10):1098-1105, October 1973.

**Abstract:** The authors describe a trial model of a nutrition and social services program for older people. One of the first steps for the program planners is to delineate the proposed service area and begin the task of surveying the needs of the older people in the area. From such analysis of needs, program planners can formulate the objectives that will provide the necessary direction and guidance for the operation of the program and provide the basis for program evaluation. The project should select a facility that is accessible and acceptable to the older persons in the area and from which the following activities and services could be provided: (1) daily meals containing not less than one-third of the recommended dietary allowance of the nutrients as described by the National Research Council; (2) counseling in the areas of health, nutrition, and social welfare; (3) information and referral services; (4) recreation activities and other opportunities for social involvement; (5) outreach activities to identify isolated and other potential consumers; and (6) transportation and escort services to meal settings and other needed social services. The authors describe the qualifications and duties of the basic core staff needed to operate a



nutrition and related service program. Staff must include (1) project director, (2) social worker, (3) secretary/bookkeeper, (4) dietary consultant, (5) cook, (6) dishwasher/janitor, (7) outreach workers, (8) volunteers, and (9) supplementary staff from other relevant public and private agencies. 5 references.  
(HE9700304)



## Issues of Aging

### Older Persons as CHA's/Older Target Populations

117

#### **Black Aged as Good Neighbors: An Experiment in Volunteer Service.**

**Form:** Journal article.

**Author:** Faulkner, A.O.

**Source:** Gerontologist. 15(6):554-559, December 1975.

**Abstract:** Researchers investigated the effectiveness of enlisting 200 elderly black persons to serve as volunteers in their communities. The project was conceived as an attempt to simulate the service that would ordinarily be given at a typical senior center. The population consisted of approximately 200 elderly black individuals in randomly selected households. The program service staff was professional and included a director and six family consultants. The family consultants were community residents who understood their fellow residents and their community's problems. Their education varied from high school graduate to 1 year of college; they were from 30 to 60 years old. The volunteers were asked to run errands, make telephone calls, write a letter or read to persons who could not, do light housekeeping chores for the ill, and offer comfort, support, and solace to the sick and the bereaved. The environment of the crime-ridden neighborhood, however, provoked security concerns that negated attempts to deploy the elderly volunteers as good neighborly participants in one-to-one contact. Additionally, the research design did not provide for enough outside or additional professional training and daily support for the paraprofessional family consultants. Researchers conclude that any attempt to institute a good-neighbor-to-good-neighbor

pattern of volunteer service must include giving volunteers sufficient training and emotional support from experienced professional social workers so that an effective volunteer program can be created within a community.

19 references. (HE9700347)

118

#### **Enhancement of Individual and Community Competence: The Older Adult as Community Worker.**

**Form:** Journal article.

**Authors:** Gatz, M.; Barbarin, O.A.; Tyler, F.B.; Mitchell, R.E.; Moran, J.A.; Wirzbicki, P.J.; Crawford, J.; Engelman, A.

**Source:** American Journal of Community Psychology. 10(3):291-303, 1982.

**Abstract:** In a 2-year primary prevention program, employed older adults served as indigenous community educators of other older adults residing in the community. The program goal was to increase adaptive strengths of both the workers and the residents along two dimensions: their self-perceived competence as individuals and their level of competence within the community. The project was conducted in 20 towns: 10 each of 2 suburban mental health catchment areas. Area A was 67.6 percent black and area B was 90.5 percent white. Median income in both areas was \$9,000. Both areas were characterized by high resident mobility. Twenty-two older people were employed as community workers (10 whites, 11 blacks, and 1 Hispanic; 18 females and 4 males). They had contact with three categories of residents: those selected at random, older adults referred to workers for particular problems, and residents selected for contact by



the workers. An evaluation focused on subsets of 78 residents who completed pre-and post-individual-competence measures. Individual competence measures assessed included self-efficacy or locus of control, interpersonal trust, problem-solving abilities, and life satisfaction. A survey of community residents assessed attitudes, knowledge, and self-reported behavior. A control group of 30 residents completed only a posttest that asked whether the residents knew about various community services and how they would solve hypothetical problems. At the same time, community workers provided residents with a resource directory of agencies and services and made themselves available to help with personal or community problems. Of the problems reported to the community workers, 76.7 percent were related to services, such as transportation, housing, clothing, food stamps, and Medicaid. Results showed that the workers and residents increased their knowledge and use of community services as a result of the program. 2 tables, 21 references. (HE9700093)

119

### **Experiences in Systematic Training in a Rural Program for Elderly Mississippians.**

**Form:** Journal article.

**Author:** Williams, L.

**Source:** American Journal of Clinical Nutrition. 26(10):1138-1142, October 1973.

**Abstract:** A community worker discusses the experiences encountered in developing a training program for elderly persons in the Mississippi Delta. The original objective of the program was to develop an agency to plan, organize, and operate a nutritional research program and demonstration for the aging poor in the area. While nutrition proved to be an important service to these individuals, it soon

became clear that many other services would be needed before the nutrition service would have any effect on the lives of the individuals being served by the agency. Soon after the program began, the agency began providing arts and crafts programs as well as other social and recreational opportunities. During the final year of operation of the agency, the directors developed a program that centered around peer education activities led by many of the elderly program participants. The program leaders selected older individuals who understood the principles of nutrition and encouraged them to teach good nutrition habits to other program participants. In all, 20 individuals in the program volunteered to become community nutrition aides. These individuals visited others who were not involved in the program, going into their homes and looking for the signs of nutritional problems. Many aides became involved in other activities in the community and in the home, and their overall outlook on life was improved. A test given by staff to program participants showed that the nutrition knowledge of participants improved. The program demonstrated the crucial importance of providing comprehensive services to the aged individual. (HE9700320)

120

### **Guidelines for Older Person Volunteers.**

**Form:** Journal article.

**Authors:** Sainer, J.; Zander, M.

**Source:** Gerontologist. 11(3, Part 1):201-204, Autumn 1971.

**Abstract:** The authors discuss the initial guidelines that emerged from Project SERVE, a program of volunteer service by older persons located on Staten Island, New York. Project SERVE was designed to test the effectiveness of group methods in recruiting, placing, training, and retaining older persons as

volunteers providing service in community agencies. About 640 volunteers were recruited, placed, and trained; more than 70 percent are still active in the program 3 years after program inception in 1967. Results of the SERVE program indicated that volunteer programs by older persons will be most successful when the program is structured to provide features that are familiar and meaningful to the social class acclimation and experiences of the potential volunteer, and least successful when it is not. Guidelines to attract and retain volunteers include (1) program staff must help the agency develop opportunities that are most appropriate to the experience and background of the volunteers being recruited; (2) the group approach is especially valuable for older volunteers; (3) the volunteer should be offered a variety of placement choices; (4) program staff gives personalized attention to each volunteer; (5) the project should make efforts to gain public recognition from the broader community; (6) volunteer transportation is essential to recruitment, placement, and retention; and (7) no potential volunteer should be turned away because of a lack of social or job skills. (HE9700348)

121

### **Health Education as a Basis for Social Support.**

**Form:** Journal article.

**Authors:** Campbell, R.; Chenoweth, B.

**Source:** *Gerontologist*. 21(6):619-627, December 1981.

**Abstract:** The authors describe the Peer Support System, an effort to complement medical programs with psychosocial support for the elderly and their families. The project was conducted in four different sites: (1) the Turner Geriatric Clinic at the University of Michigan Hospital (the ongoing site), (2) a senior

nutrition site, (3) a nursing home, and (4) a community hospital in a rural area. The objectives of the project were to involve older people in the provision of mental health services, including health education, in coordination with existing community agencies. The program consisted of recruiting and training peer counselors and conducting monthly health education workshops. The peer counselors were recruited in their own communities and trained at the site where they would work. Eighteen hours of training were scheduled and conducted by a social worker and psychiatric nurse. Training sessions were followed by meetings twice a month. Overall training goals were (1) to teach peer counselors how to conduct workshops that would best meet the needs of the people at their site, (2) to develop awareness in peer counselors of their own special skills and interests, and (3) to acquaint the peer counselors with each other, thereby establishing a sense of identity as a peer counselor group. The health-focused workshops were initiated first since it was believed they would attract a broad audience of older adults. Small discussion groups were facilitated within the large workshop when the peer counselors thought the issues addressed appeared to warrant further exploration. Participants expressing the need for individual attention were contacted by peer counselors and staff. Finally, the information generated in the workshops was compiled and distributed to an even wider audience of all ages. Staff included 1 part-time social worker, 1 full-time psychiatric nurse, 1 part-time program assistant, and 17 graduate students working in various capacities during the 2-year period. To monitor the effectiveness of the program, evaluations were performed among workshop participants and among the peer counselors. During a 2-year period, 48 peer counselors developed programs for 2,500 people, accounting for



5,000 participant contacts. 1 table, 25 references. (HE9700614)

122

### **Impact of Race on Volunteer Helping Relationships Among the Elderly.**

**Form:** Journal article.

**Authors:** Morrow-Howell, N.; Lott, L.; Ozawa, M.

**Source:** Social Work. 35(5):395-402, September 1990.

**Abstract:** Researchers sought to better understand volunteer behavior by exploring how race influences relationships between volunteers and the people they serve. Data sources included 83 volunteers in the community self-help program, 246 clients in the same community self-help program, and 1 agency staff member. Trained interviewers conducted in-home interviews with the volunteers and their clients from January 1 through July 31, 1985. An agency staff member provided information about the effectiveness of the volunteers from a professional perspective. The researchers obtained descriptions of the volunteers' age, education, income, physical functioning, health, mental health, and social support to determine whether differences existed in personal characteristics between black and white volunteers. Staff rated volunteers' overall effectiveness based on helpfulness, attendance, perception of training, time spent in volunteer activities with clients, and ratings of effectiveness by professional staff. Three variables measured client evaluation of volunteer behavior: level of telephone contact, level of in-person contact, and ratings of helpfulness. The analysis revealed that race alone does not affect volunteer helping behavior; black and white older adults perform similarly in volunteer roles on measures of time committed to service and

satisfaction levels of clients. However, the racial composition of the dyad does have significant effects on the helping relationship; higher levels of contact and client satisfaction were reported when the volunteer and the client are of the same race. Researchers conclude that training and support are necessary to overcome problems associated with racial differences between volunteers and their clients. 5 tables, 35 references. (HE9700085)

123

### **Is Volunteering a Substitute for Role Loss in Old Age? An Empirical Test of Activity Theory.**

**Form:** Journal article.

**Author:** Chambre, S.M.

**Source:** Gerontologist. 24(3):292-298, June 1984.

**Abstract:** An educator sought to determine whether volunteering is used as a substitute for role loss in old age by examining whether individuals who lack ties to work and to family tend to volunteer more frequently and to devote more time to volunteering than do those maintaining such involvement. Two measures of volunteering were used: (1) volunteer participation, as determined by responses from 4,339 participants who had been asked whether they had performed any unpaid volunteer work between April 1973 and April 1974, and (2) commitment of volunteers, which was based on a score assigned to individuals in response to the frequency and total number of hours they had volunteered in the past year. Discussions of the importance of volunteering for the elderly reflect the influence of activity theory, which suggests that volunteering is a work substitute; study findings, however, suggest that other social characteristics such as socioeconomic status and sex have a greater influence on volunteer patterns of the elderly. The educator



concludes that an understanding of the level of volunteer activity among the elderly cannot be explained by activity theory, and may be better addressed by applying continuity theory. 7 tables, 22 references. (HE9700082)

124

### **Natural Helping Among Older Adults.**

**Form:** Journal article.

**Author:** Goodman, C.C.

**Source:** *Gerontologist*. 24(2):138-143, April 1984.

**Abstract:** A professor of social work at the University of Southern California reports on a survey of neighbors in retirement housing that sought to identify distinguishing characteristics and natural helping styles of persons within a dynamic informal support system. The study asked what demographic, social, health, and personality characteristics were related to social exchange types: high helpers, mutual helpers, and isolated persons in the neighborhood who neither give nor take actively with neighbors. A sample of 67 elderly persons was drawn randomly to represent residents of two purposively selected, age-segregated housing developments within a single middle-income community. The 2-hour interviews contained open-ended questions to elicit acts of giving and taking for specific neighbors.

Demographic characteristics such as age, sex, marital status, ethnicity, religious affiliation, education, and previous occupation were measured. Findings confirm a typology of three neighborhood exchange types: (1) high helpers, who exhibit a quasiprofessional style of helping without reciprocation; (2) mutual helpers, who show an interdependent style of give and take; and (3) neighborhood isolated people, whose social ties and help sources are primarily located outside the neighborhood. The social exchange types identified in this

study offer a foundation on which to build program models that can more closely address community weaknesses and capitalize on community strengths. 1 figure, 1 table, 21 references. (HE9700083)

125

### **Older Rural Natural Helpers: Gender and Site Differences in the Helping Process.**

**Form:** Journal article.

**Author:** Patterson, S.L.

**Source:** *Gerontologist*. 27(5):639-644, October 1987.

**Abstract:** Researchers sought to describe the characteristics of older, rural, natural helpers, to help recipients examine the kinds of assistance elderly helpers provide to different types of recipients, and to identify similarities and differences in the helping process used by female and male helpers in two different regions of the country. The type of helper sought for interviewing was defined as one who provides spontaneous, informal help to relatives, friends, and neighbors, usually on a one-to-one basis. In all, 91 people from rural locations (45 from the Midwest and 46 from New England) were identified as helpers from a pool of people identified by community groups and individual residents. In-person interviews were conducted with 40 older individuals in each site by experienced social workers. The Natural Helper Interview Schedule was constructed to obtain information on (1) helper and recipient characteristics, (2) helping techniques, (3) relationships, (4) helper style, (5) problem type, (6) perceived outcome, and (7) effectiveness (helpfulness). All identified helpers were white, the majority were in their 60's and 70's, married, relatively well educated, Protestants, and retired or homemakers. The recipients were the relatives, friends, and neighbors of the helpers; the majority of

recipients, whether employed or retired, held or had held skilled rather than professional positions. Results indicate that although female and male helpers were similar on demographic variables, there were marked sex differences associated with helper motivation, help initiation, helping style, and perceived outcome. More females, for example, cited caring about people as their major motivation for helping whereas more men reported being motivated by a sense of moral obligation to help others. Conversely, few site differences emerged in two dissimilar regions of the country. The study has implications for mental health professionals in identifying and understanding the preventive and restorative activities of older relatives, friends, and neighbors in rural communities. 4 tables, 31 references. (HE9700080)

126

### **Older Volunteers: A Discussion of the Minnesota Senior Study.**

**Form:** Journal article.

**Authors:** Fischer, L.R.; Mueller, D.P.; Cooper, P.W.

**Source:** *Gerontologist*. 31(2):183-194, April 1991.

**Abstract:** Using findings from the Minnesota Senior Study, researchers examine the theoretical and methodological difficulties of defining, coding, and analyzing data on older volunteers and present a conceptual model for defining and categorizing forms of voluntary service. Conducted during 1988 to 1989 by the Wilder Research Center, the Minnesota Senior Study consisted of a telephone survey of a representative statewide sample of approximately 1,500 noninstitutionalized Minnesotans over age 59 years. Conducted to gather data on how the elderly contribute to society and to assess their needs, the survey questionnaire addressed (1) demographic

characteristics; (2) housing; (3) transportation; (4) health and daily functioning; (5) social supports; (6) employment; and (7) participation in volunteer work. The study found that 52 percent of Minnesotans do volunteer work for organizations, a rate considerably higher than that found in national surveys. Problems in definition and methodology, however, have confounded analyses. Researchers conclude by proposing a new conceptual model for classifying volunteer roles, based on three dimensions: whether volunteer service is formal (volunteer work for an organization) or informal (voluntary services to individuals); whether the activity entails a regular or an occasional time commitment; and the nature of the service activity (person-to-community, person-to-object, or person-to-person). 3 tables, 23 references. (HE9700079)

127

### **Older Volunteers Use and Learn Special Skills in Seven Model Health Projects.**

**Form:** Journal Article.

**Author:** Hickey, J.C.

**Source:** *Hospitals*. 52(22):128-130, 132, November 16, 1978.

**Abstract:** Health education programs across the country have benefited from elderly persons acting as volunteer health educators or counselors. Working with existing organizations and institutions, the Clark Foundation has invested \$10 million of its own and \$30 million received from external funding sources to finance efforts to recruit and train older people to meet community needs. With the assistance of the Hospital Research and Educational Trust, an affiliate of the American Hospital Association, the foundation helped establish 3-year demonstration projects in 1977 that used 300 elderly volunteers in 7 hospitals. The volunteers have assisted programs designed to



provide comprehensive discharge planning and follow-up support, counseling and group therapy, public relations, health care needs assessments, planning services, educational services, and data collection and analysis services. Health education centers, screening services, telephone counseling, and pararesearch services have been established. Addresses for information on health care projects for older volunteers are listed. (HE7900412)

128

### **Psychosocial Differences Between Elderly Volunteers and Non-Volunteers.**

**Form:** Journal article.

**Authors:** Hunter, K.I.; Linn, M.W.

**Source:** International Journal of Aging and Human Development. 12(3):205-213, 1980-1981.

**Abstract:** Researchers examined the differences between elderly persons who volunteer and those who do not participate in such activities. The sample included 53 volunteers and 49 nonvolunteers over age 65 years; all participants were retired from paid work. The volunteers offered their services at the Veterans Administration Hospital (VAH) in Miami, Florida, on a regular, assigned basis. Researchers interviewed all volunteers during working hours. Nonvolunteers were interviewed individually for approximately 1.5 hours in private apartments within a senior citizen's housing complex, a senior day center, and in various outpatient clinics of the VAH and University of Miami-affiliated hospitals. Data collected included background and demographics and dimensions of psychosocial adjustment. Background and demographic data included (1) marital status, (2) age, (3) number of years in school or professional training, (4) household composition, (5) parental

birthplace, (6) alcohol consumption, (7) smoking behavior, (8) stressful life events, (9) medication, (10) surgical history, (11) sensory-motor function, (12) ambulation, (13) ability to perform various daily activities, and (14) experience with pain. The dimensions of psychosocial adjustment included (1) locus of control; (2) symptomology; (3) anxiety, depression, and somatization factors; (4) life satisfaction; (5) self-esteem; and (6) will to live. The results indicated there were no significant differences between the volunteer and nonvolunteer groups in (1) sex; (2) age; (3) number of years of school or professional training; (4) degree of religious feeling; (5) diet; (6) social class; (7) household composition; (8) number of surgical operations; (9) amount of pain typically experienced; (10) level of alcohol consumption; (11) smoking behavior; (12) ability to function in activities of daily living; (13) incidence of stressful life events; or (14) unusual marital, financial, or legal problems. Compared with nonvolunteers, the elderly volunteers were significantly more satisfied with life; had a stronger will to live; and reported fewer somatic, anxious, and depressive symptoms. Analyses and results do not conclude a cause and effect process, yet documentation suggests that many of those engaged in volunteer activities feel that such work has changed their lives for the better. Researchers suggest a study be conducted to investigate if a program of volunteer activities initiated for those elderly who have symptoms of depression, anxiety, or general dissatisfaction with life would in fact change their state of mind in any significant way. 3 tables, 20 references. (HE9700342)



129

**Recruitment and Orientation of Older Volunteers in Extended Care.**

**Form:** Journal article.

**Authors:** Davidhizar, R.; Bowen, M.

**Source:** Nursing Management. 26(12):42, 44, December 1995.

**Abstract:** Educators discuss ways to increase volunteerism among older persons. Compared with younger persons and staff, older persons often have more time to listen and to give patients and residents personal attention. The most effective way to recruit volunteers is through word-of-mouth, solicitation by personal contacts, suggestions of present volunteers, and personal invitations. Suggestions and personal invitations by present volunteers offer the additional advantage of modeling. Recruitment is more likely if volunteer times are scheduled to meet older persons' needs. Older persons who have volunteered previously are more likely to volunteer again and thus are easier to recruit than are new volunteers. Careful selection can result in volunteers who are more likely to be active, committed, and loyal. Careful matching of volunteers to programs has been found to promote retention. An effective orientation program for older volunteers must stress that (1) all information about patients must be kept confidential; (2) once volunteers' time has been scheduled, they must notify the agency if the commitment cannot be kept; (3) the volunteer may not offer opinions or advice on medical problems to patients; (4) the volunteer assists patients or residents in independent living; and (5) the volunteer should not become personally involved with patients and residents. The program should (1) provide volunteers with tips on effective communication techniques; (2) emphasize that doing little things for patients can be highly significant (e.g., letters, cards, walking with a patient for

exercise, and chatting can be important to patients' happiness); (3) provide volunteers with information on patients' requirements (e.g., the need to repeat things several times for patients with memory or orientation problems); (4) mention the rewards for volunteerism (e.g., how other volunteers have been appreciated by patients); and (5) discuss where the volunteer should report and to whom. 11 references. (HE9700066)

130

### **Activity and Similarity in Safer Sex Workshops Led by Peer Educators.**

**Form:** Journal article.

**Authors:** Reeder, G.D.; Pryor, J.B.; Harsh, L.

**Source:** AIDS Education and Prevention. 9(Supplement A):77-89, February 1997.

**Abstract:** Researchers examined the effectiveness of peer-led safer sex workshops that were designed to encourage condom use among sexually active college students. The evaluation focused on two variables: the amount of audience involvement in workshop activities, and the similarity of the peer educators to their audiences. Participants were recruited from a general education course offered by the Psychology Department at Illinois State University (ISU). The students were predominantly white females, with a median age of 18 years. The sample consisted of 171 students who were randomly assigned to one of four safer sex workshops or to a control group. Workshop formats were activity-based with either similar or dissimilar peer leaders, or information-based with either similar or dissimilar peer leaders. All students completed a questionnaire before and immediately after the workshop and again a month later. The activity and information workshops presented the same content in the same order, but participants in the activity workshops completed a series of small-group exercises; those in the information workshops played a relatively passive role. Peer leaders with similar beliefs as their audiences identified themselves as members of the ISU Peer Education Program and described personal views of premarital sex that were thought to be typical of ISU students. Those with dissimilar beliefs said that they were from Illinois

Wesleyan University and stated that their personal religious beliefs were opposed to premarital sex. The dependent measures included perceived similarity to the peer leader, attitudes toward the workshop, knowledge of sexually transmitted diseases and condom use, self-reported condom use (for current partners) or intention to use condoms with new partners, self-efficacy, response efficacy, and perceptions of social norms. Results indicated that the activity format was more effective than the information format in encouraging condom use during the month following the workshop. In addition, the similarity of the peer leaders influenced behavioral intentions to use a condom with new partners. The researchers concluded that the effectiveness of peer education may be enhanced by including activities and by using peer leaders who are similar to the target audience. 3 tables, 26 references. (HE9700783)

131

### **Communication Skills Training for Paraprofessional Helpers.**

**Form:** Journal article.

**Author:** Avery, A.W.

**Source:** American Journal of Community Psychology. 6(6):583-591, December 1978.

**Abstract:** Investigators constructed and evaluated a communication skills training program for paraprofessional helpers. The 35 participants included 34 undergraduate students and 1 graduate student who had been selected, based on grade point average and term standing, to receive training as residence hall counselors at the Pennsylvania State University. The first 20 candidates, including 11 males and 9 females, received training for immediate openings (the experimental group), while the

other 15 candidates, including 11 males and 4 females, were to be trained at a later time (the control group). Investigators selected the dimension of empathy as the dependent variable because of its significance as an essential condition in the helping relationship. They selected the Carkhuff Empathy Scale as the measure of the dependent variable. The experimental and control groups had no significant differences in age, initial level of empathy (based on pretest data), and amounts of prior helping experience (based on the initial counselor application). As a pretest, investigators gave members of both the experimental and control groups the opportunity to help a person in a 15-minute audiotaped helping interview at the outset of the study. The individuals presenting problems to the participants in the interview were confederates who were supervisory residence staff personnel with extensive experience in role-playing student problems. After completing the pretest, the experimental group received 20 hours of training; the control group received no training at this time. Following the training, as a posttest, members of both groups counseled a person similarly to the pretest. Independent judges rated the pretest and posttest audiotapes. The results indicated that the trained participants demonstrated significantly higher levels of empathy than did the untrained participants and that they maintained their level of empathy after 6 months. 1 table, 13 references. (HE9700331)

132

### **Developing Capacities of Youth as Lay Health Advisors: A Case Study With High School Students.**

**Form:** Journal article.

**Authors:** Berkley-Patton, J.; Fawcett, S.B.; Paine-Andrews, A.; Johns, L.

**Source:** Health Education and Behavior. 24(4):481-494, August 1997.

**Abstract:** The Peer Helping Program (PHP) is a youth lay health advisor (YLHA) program designed to increase high school students' ability to provide emotional and social support to their peers. The PHP was implemented in a large high school (grades 10 through 12) in a midwestern city. The student population was predominantly white and was experiencing a variety of problems, including a lack of extracurricular capacity, overcrowding, and high levels of risky behaviors. The PHP was developed as a collaborative partnership among the students, school staff, representatives from local mental health and prevention agencies, university students, and other members of the community. The PHP established a comprehensive program development plan, identified funding sources, and secured an evaluation team. The primary program goals were to (1) increase the number of students qualified to provide support and assistance to their peers, (2) provide effective training to equip students with peer helping skills, (3) use YLHA's to assist peers in problem solving and to promote a supportive school environment, and (4) refer students to local counseling services for critical situations. The student body was surveyed to identify those peers to whom students believed they would go for help and the problems for which they would seek help. All prospective YLHA students attended an initial overnight training retreat, followed by monthly training sessions on specific problem



areas. A total of 24 YLHA's were trained (19 girls, 5 boys). Several strategies were used to promote the PHP, including personal contact with students, morning announcements on the intercom system, posters, flyers, and coverage in the school and local city newspapers. A rapid formative evaluation was conducted to assess the YLHA's satisfaction with the training retreat, measure changes in peer-helping skills after training, monitor YLHA helping contacts, and obtain YLHA's perspectives about the program's accomplishments, challenges, and future. Future PHP plans included (1) lowering the social stigma of seeking counseling from the PHP through advertising and advocacy; (2) creating a more comfortable, accessible environment for the program; (3) learning more about specific problems and how to deal with them; and (4) increasing the involvement of school administrators in the program. 3 tables, 39 references. (SA9700921)

133

### **Evaluation of Prototype School-Based Peer Counseling Program.**

**Form:** Journal article.

**Authors:** Kim, S.; McLeod, J.H.; Rader, D.; Johnston, G.

**Source:** Journal of Drug Education. 22(1): 37-53, 1992.

**Abstract:** Researchers report outcome evaluation results of a 1-year prototype peer counseling program at a North Carolina high school. The evaluation measured (1) the peer counseling program in terms of program content as evaluated by the trainees, (2) instructor quality as perceived by the trainees, (3) several instrumental objectives deduced from the peer counselor training program, and (4) the degree to which the program reached other students at the high school. School administrators and faculty recommended

potential counselor candidates; the school counselor coordinated and supervised the program. The peer counseling student volunteers received training composed of (1) video sessions, (2) processing sessions (a discussion period in which participants work through problem situations by participating in group discussions and skits), and (3) a 2-day outdoor camp with activities designed to promote trust among the peer counselors and to instill the concept of teamwork. The most common student problem areas encountered by the peer counselors included conflict with boy/girlfriends, depression, and parent/family conflict. Using the Peer Counseling Activities Log process evaluation instrument, peer counselors logged each counseling situation. Researchers used the Peer Training Evaluation Instrument, a completely anonymous and self-administered questionnaire, to evaluate the program. The instrument contained 51 Likert-type scale items measuring the instrumental objectives of the peer counseling program and probing the program participants' reaction to the peer counseling program and its instructor. For the outcome evaluation, researchers compared students' overall reaction to program content and to the instructor with corresponding student evaluations of regular school work and regular school teachers. In the absence of a control group, researchers determined the program's treatment effect in terms of individual growth curve models. The multiple evaluations indicated that a significantly larger proportion of students in the peer counseling group had more favorable attitudes toward the program content than toward regular school curriculum content. A significantly larger proportion of students in the peer counseling program reported more favorable attitudes toward peer counseling instructors than toward regular schoolteachers. The peer counseling program improved trainee self-esteem and advanced social values between pretesting and

posttesting, but did not generate significant attitudinal improvement in basic social values, student-teacher relationship, student motivation level, and their attitude on school value. 6 tables, 33 references. (HE9201424)

134

### **How Peer Education Changed Peer Sexuality Educators' Self-Esteem, Personal Development, and Sexual Behavior.**

**Form:** Journal article.

**Authors:** Sawyer, R.G.; Pinciaro, P.; Bedwell, D.

**Source:** Journal of American College Health. 45(5):211-217, March 1997.

**Abstract:** Researchers evaluated changes in self-esteem, personal development, and sexual behavior among college peer educators as a result of their participation in peer sexuality education programs. The study population consisted of 119 previously untrained college students who registered to participate in their respective institutions' peer education programs for a full academic year. Researchers examined sexuality peer education programs from 10 universities throughout the United States. Each university had a total enrollment of more than 10,000 students and had had established peer education programs for more than 3 years. Researchers collected data from the peer educators three times during the course of an academic year. Pretest data were collected on the first day of peer training before any actual training had commenced. The first posttest was administered just before the winter break and the final posttest at the end of the academic year. The pretest survey contained 12 demographic items, the Rosenberg Self-Esteem Scale, the Personal Development Inventory, and the Safe Sex Behavior Questionnaire. The first and second posttests included the three questionnaires plus several open-ended items

related to the peer educators' experience. All of the peer educators completed the pretest, 95 completed the first posttest, and 65 completed the final posttest. In their analyses, researchers included only the 65 students who completed the pretest and both posttests. The peer educators were predominantly female and ranged in age from 18 to 31 years. Results showed positive changes in the peer educators' self-esteem, personal development, and safe sex behavior, although the increases were not statistically significant. The researchers recommended conducting additional research with a larger population of peer educators. They also recommended that efforts to justify peer education programs focus more on the peer educators rather than solely on evaluations of knowledge gains in program recipients. 2 tables, 18 references. (HE9700782)

135

### **Peer Counselor Training Program: Rationale, Curriculum, and Evaluation: An Initial Report.**

**Form:** Journal article.

**Authors:** Dorosin, D.; D'Andrea, V.; Jacks, R.

**Source:** Journal of the American College Health Association. 25(4):259-262, April 1977.

**Abstract:** Educators discuss their experiences with peer counseling training among student groups. Because many student group members expressed an interest in peer counseling training, the educators evaluated and conceptualized several themes of motivation by the students to characterize their interest in training to be peer counselors. It became apparent through discussion that the student groups were motivated by issues such as heightening access to peer communication for solitary individuals, emotional support, and increasing and supporting self-definition. Based on the responses received by the



educators, they developed a peer training course based on the microcounseling technique. The emphasis of the course was on skill learning through the use of videotape for both content and for immediate feedback of role playing. Evaluation of the training course included three major components: (1) ongoing evaluation by both the students and trainers of the sessions, (2) systematic evaluation of the effect of the training on learned skills, and (3) evaluation of the actual counseling by the people who have taken the training. 1 figure, 5 references. (HE9700322)

136

### **Peer Nutrition Education Programs on College Campuses.**

**Form:** Journal article.

**Authors:** Horacek, T.M.; Betts, N.M.; Rutar, J.

**Source:** Journal of Nutrition Education.

28(6):353-357, November-December 1996.

**Abstract:** Researchers determined the prevalence and scope of peer nutrition education programs on college campuses and made recommendations for initiating a program. Surveys, sent to all 234 directors for Didactic Programs in Dietetics, included items regarding (1) the existence of peer nutrition education programs; (2) how long such programs had been in place; (3) how the programs were coordinated; (4) peer education demographics and training; (5) program funding; (6) services provided; (7) program evaluation; and (8) other areas of interest, such as problems experienced and advice for starting a program. Researchers developed the survey based upon existing literature and piloted it with three nutrition science faculty members. Of the 115 schools that returned surveys, 26 reported they had peer nutrition education programs. Most of the programs (92 percent) used dietetic students as educators, with the

number of peer educators participating in the programs ranging from 1 to 50, with an average of 14 per program. Twenty-two of the programs (86 percent) reported that they provided additional training for their peer nutrition educators. Programs were most often funded by department funds or student fees but a few were funded through grants. For the majority of the programs, the educators' time was devoted first to counseling and assessment, then to outreach. Most programs reported offering a wide variety of outreach presentations for their student population. Respondents reported a number of public relations and program evaluation strategies as well as problems their programs had encountered and advice on starting a program. The researchers concluded with a number of suggestions on beginning a peer nutrition education program. 2 tables, 21 references. (HE9700461)

137

### **Peer Participation in Project Northland: A Community-Wide Alcohol Use Prevention Project.**

**Form:** Journal article.

**Authors:** Komro, K.A.; Perry, C.L.; Veblen-Mortenson, S.; Williams, C.L.

**Source:** Journal of School Health. 64(8):318-322, October 1994.

**Abstract:** Researchers describe the rationale, conceptual framework, and program components of Project Northland, a peer participation program for prevention of alcohol use among young adolescents. Program goals included (1) providing peer leadership and social support for nonuse of alcohol, (2) creating opportunities for behavioral alternatives to alcohol use, and (3) creating a norm of nonuse among young adolescents. Researchers implemented the program with seventh-grade students in 20 northeastern



Minnesota schools. Community coordinators recruited 33 adult volunteers to facilitate peer groups in the schools. At an initial Project Northland peer leadership group meeting, students from each school selected two to five representatives to attend one of two leadership training sessions. Researchers designed the training sessions to increase peer leaders' involvement in prevention efforts, create excitement about being part of the program, and empower students to plan, participate, and promote alcohol-free activities. Peer leaders chose to call the program TEENS (The Exciting and Entertaining Northland Students). During the first year of the program, peer leaders organized 62 supervised, alcohol-free activities. Most peer leadership groups met during the school day, during lunch period or study hall. Most TEENS members (71 percent) believed that their classmates liked the activities, and 86 percent thought that their classmates had fun at the activities. The peer leaders planned a variety of activities, including an open gym and movies held at the school on weekend nights, dances, ski trips, roller skating, bowling, tubing, and beach parties. Findings suggest the need and indicate support for peer-planned, alcohol-free activities. 1 figure, 23 references. (SA9500321)

138

### **Personal and Situational Determinants of Volunteer Recruitment for a Campus Hotline Program.**

**Form:** Journal article.

**Author:** Turner, J.R.

**Source:** Journal of the American College Health Association. 21(4):353-357, April 1973.

**Abstract:** The author evaluated some of the personal and program variables that might identify and increase the number of dependable student volunteers working for student peer

hotlines. The study sample included 169 undergraduates (69 males and 100 females) who were recruited as student volunteers for a peer hotline. These individuals were divided into three different groups according to their responses to recruitment after an initial meeting about the volunteer program: (1) Definitely volunteering, (2) definitely not volunteering, and (3) ambivalent about volunteering. The volunteer group, 28 males and 36 females, said that they wanted to participate in the program and attended a minimum of 2 meetings. The nonvolunteers, 21 males and 20 females, stated during the first meeting that they had no intention of participating further in the program. The potential volunteers, 20 males and 44 females, said that they had intended to serve, but after learning about the time required, had decided not to participate because of other commitments. On an application form to the program, researchers asked students to describe themselves using the 300-item Adjective Check List. They also used the Social Action Survey to measure student attitudes toward the program's general concept of students helping other students, and the Test of Counselor Attitudes which contained the following five scales: (1) evaluative, (2) interpretive, (3) understanding, (4) supportive, and (5) probing. Results showed that volunteers as compared with nonvolunteers and potential volunteers were more self-controlled, tolerant, and dedicated to social improvement. The attitude of the volunteers toward service recipients was more supportive. A consistent sex difference in the volunteer group was that the male volunteers were strongly oriented toward helping others while female volunteers wanted to learn and achieve academically. Overall, the group of potential volunteers differed more markedly from volunteers than from nonvolunteers. From the results of the study, it appears that recruiting literature encouraging students to volunteer should emphasize the dual

opportunity to help and learn simultaneously.  
3 tables, 13 references. (HE9700321)

139

**Programmatic Prevention of Adolescent Problem Behaviors: The Role of Autonomy, Relatedness, and Volunteer Service in the Teen Outreach Program.**

**Form:** Journal article.

**Authors:** Allen, J.P.; Kuperminc, G.; Philliber, S.; Herre, K.

**Source:** American Journal of Community Psychology. 22(5):617-638, 1994.

**Abstract:** Researchers conducted a study in order to identify factors explaining the differing relative effectiveness of Teen Outreach programs in reducing problem behaviors at different sites. Specifically, they examined whether positive site outcomes would be predicted by (1) the degree to which a site was seen by students and facilitators as supporting students' developmental need for a sense of autonomy and relatedness within the program and (2) the extent to which students believed the volunteer community service that they performed encouraged them to learn new skills, to think about their life goals, and to influence the nature of the work performed. From 1987 to 1992, researchers evaluated 1,020 students at 66 sites who participated in the Teen Outreach Program and 1,013 comparison students. Study participants filled out a brief self-report questionnaire indicating their age, school grade level, race, household composition, and parents' education levels. Information was also gathered on whether they had ever been pregnant or had caused a pregnancy, and whether they had failed any courses or been suspended during the school year. The researchers assessed the variations in the implementation of Teen Outreach at different sites by administering questionnaires to both participants and

facilitators during the final month of the program. Results show that middle school sites that promoted student autonomy and relatedness with peers and site facilitators achieved significantly reduced problem behaviors. Although the program was equally successful with students from a wide range of sociodemographic backgrounds, links of program factors to site-level outcomes were found for middle school but not high school sites. The researchers conclude that the success of an effective intervention to prevent adolescent problem behaviors is linked both to its promotion of students' sense of autonomy and relatedness and to autonomy-enhancing qualities of volunteer experiences provided to participants. 4 tables, 37 references. (SA9700001)

140

**Reducing Health Risks Through Peer Health Education: A Preliminary Report.**

**Form:** Journal Article.

**Authors:** Nagelberg, D.B.; Hodge, J.M.; Ketzer, J.M.

**Source:** Journal of the American College Health Association. 28(4):234-235, February 1980.

**Abstract:** The student health service of Bowling Green (Ohio) State University initiated the Health Risk Reduction Program to promote student health by increasing self-awareness and personal responsibility for health. The traditional pre-enrollment physical examination was replaced by a self-reported medical health inventory called the Database Acquisition for Student Health. Data from the inventory were analyzed and students received a health risk index outlining their health status. Peer health educators, selected from groups of upper class or graduate students, counseled the students. Faculty and staff members in the health,



nutrition, health and physical education, psychology, social work, and education fields selected the paraprofessional peer educators. The candidate educators attended a 10-week course, during which a psychologist and an educator instructed them in health content areas, process skills, and practicum training topics. The potential peer educators also viewed and evaluate videotaped interviewed with students. Each educator interviewed four to five freshmen each week. Approximately 300 freshmen were interviewed each academic quarter. A survey of 108 freshmen who met with a peer educator during 1979 and 100 freshmen who received their inventory results through the mail indicated that student attitudes toward the educators were favorable and that the educators clarified students' perceptions of inventory results. 7 references. (HE8101097)

141

### **School-Based Prevention of Teen-Age Pregnancy and School Dropout: Process Evaluation of the National Replication of the Teen Outreach Program.**

**Form:** Journal article.

**Authors:** Allen, J.P.; Philliber, S.; Hoggson, N.

**Source:** American Journal of Community Psychology. 18(4):505-524, August 1990.

**Abstract:** Researchers describe process-oriented evaluation data from the Teen Outreach Program, a preventive intervention that attempts to prevent school dropout and teenage pregnancy. The program was designed to provide meaningful volunteer service experiences and classroom-based discussion opportunities to young people at risk for significant behavioral problems (such as dropout and pregnancy). Researchers examined naturally occurring variations in the implementation of the program at 35 different sites in 30 schools nationwide. Within each

site, investigators assessed four types of factors potentially relevant to program success: (1) student demographics (age, race, sex); (2) structural program factors (whether the program was given during or after school and whether or not it was offered for credit); (3) program intensity factors (number of hours spent in classroom discussions and in volunteer activities); and (4) curricular factors (use of various parts of the Teen Outreach curriculum). Participants included 632 students from the program and 855 comparison students, ranging in age from 11 to 19 and from grades 7-12. Study measures included self-report questionnaires on demographic characteristics and problem behaviors and collection of information from Teen Outreach facilitators on program intensity, structure, and curriculum. Researchers assessed students at program entry (fall) and exit (spring). Results indicated that Teen Outreach site staff were most successful when they worked with older students and when the volunteer component was more intensively implemented at a site. Work with younger students was more successful when it contained more intensive classroom components. Students' sex and minority status appeared unrelated to their success in the program. Results highlight the need to be developmentally sensitive in targeting and evaluating prevention programs for different age groups. 3 tables, 32 references. (SA9400143)



142

**Skin Cancer Prevention: A Peer Education Model.****Form:** Journal article.**Authors:** Reding, D.J.; Fischer, V.; Gunderson, P.; Lappe, K.**Source:** Wisconsin Medical Journal. 94(2):77-81, February 1995.

**Abstract:** Researchers related the results of a demonstration project to deliver skin cancer prevention education to youth. The project was conducted in the 1991-1992 school year as part of the Wisconsin Farmers' Cancer Control Program to improve access to cancer education and screening for rural residents. American Cancer Society staff, school curriculum committees, and representatives of the Future Farmers of America (FFA) contributed to the project's plan. The FFA practices peer education, whereby older students teach younger children about agriculture. FFA members from six northern Wisconsin high schools carried out the project. They used the Children's Guide to Sun Protection K-3, developed for students in grade three, as the intervention. The curriculum included background information on the basic anatomy of the skin, skin cancer, the sun and the damage it causes, and methods of sun protection. At a 1-day workshop, 40 FFA members received training on skin cancer and sun protection, on teaching skills, and on administering the surveys. The intervention consisted of 10 questions about sun protection. The students answered preprogram, postprogram, and 6-month follow-up surveys, while control groups answered the identical survey but had no sun protection education session between the preprogram and the postprogram surveys. The researchers compared the results of the experimental groups with those of the control groups, using chi-square tests and the Mann-

Whitney U test. The students could take home (1) activity sheets, (2) a skin cancer brochure developed specifically for farmers, (3) an informational skin cancer sheet, (4) a bookmark with sun protection guidelines, and (5) a sunscreen sample. Seven third-grade classrooms acted as controls. Overall, the intervention group had significantly improved scores on the postsurvey compared with the control group. The control groups participated in the sun protection education after the postsurvey, which made it difficult to interpret the results of the 6-month follow-up data. The FFA facilitators completed presurveys, postsurveys, and follow-up surveys, showing an improvement in their knowledge and intended behavior. The findings demonstrate the effectiveness of peer facilitators in educating younger students about skin cancer. 2 tables, 12 references. (CP9500302)

143

**Teens Teach Skin Cancer Prevention.****Form:** Journal article.**Authors:** Reding, D.J.; Fischer, V.; Gunderson, P.; Lappe, K.; Anderson, H.; Calvert, G.**Source:** Journal of Rural Health. 12(4, Supplement):265-272, 1996.

**Abstract:** Researchers report on a program designed to deliver sun protection education to youth, using members of the Future Farmers of America (FFA) as peer educators. They based the program on the hypothesis that a school-based sun protection education program delivered by youth facilitators would result in increased sun protection knowledge among younger children. Facilitators of the program were 217 teenaged educators from 39 FFA organizations throughout Wisconsin who were trained at a 1-day workshop involving (1) information on skin cancer and sun protection, (2) the introduction and practice of the sun

protection curriculum, and (3) teaching skills training. The youth facilitators delivered a presentation on sun protection to 2,007 third graders. Topics covered included background information on (1) the anatomy of skin, (2) skin cancer, (3) the sun, and (4) methods of sun protection. The presentation emphasized the ABC's of sun protection (Away, Block, Cover up, and Speak Out). Facilitators administered a survey consisting of 10 questions to the third graders before, at the conclusion of, and 6 months after the presentation. Control schools included 57 facilitators and 669 third graders who were surveyed in the same manner as the intervention groups, with no education session offered. Students who responded correctly to a question on the postsurvey after responding incorrectly on the presurvey were said to have a knowledge gain for that question. Results showed (1) there were no significant differences between the intervention and control groups for any of the presurvey questions, (2) the intervention group had a significantly higher proportion of students experiencing knowledge gain than did the control group postsurveys, and (3) the intervention group showed significant improvement in skin cancer prevention techniques. 3 figures, 2 tables, 28 references. (CP9700236)

144

### **Utilization of Peers in a College Crisis Intervention Program.**

**Form:** Journal article.

**Authors:** Grant, C.H.; Hubble, K.O.; Helm, C.J.

**Source:** Journal of the American College Health Association. 21(4):327-332, April 1973.

**Abstract:** Based on the general effectiveness of the University of Nebraska Health Center's aide program, the Crisis Health Aide program used crisis intervention and anticipatory

guidance approaches to aid individuals in developing more adequate coping skills to deal with the problems of daily life. Crisis health aides help individuals work through some of the feelings that accompany every crisis and aid in problem solving, wherever possible. The specific goals of the crisis health aides include (1) helping fellow students in crisis, (2) helping define immediate problems as separate from past ones, (3) discussing with the student possible solutions and alternatives, and (4) offering referrals for further professional help. Crisis health aides are selected on the basis of an application, a short autobiographical sketch, and a screening interview. All candidates participate in a series of four to six training sessions. Crisis health aides are paid members of the Health Center staff under the direct supervision of mental health staff members. Evaluation of the center to date reveals that the center seems to be functioning in a much broader capacity than originally intended. In addition to providing students with help in resolving emotional and physical crises, the Crisis Health Aide Center serves as an after-hours point of access to the university health care delivery system, as a medical referral service, and a general information service for the university community. 4 tables, 6 references. (HE9700314)



## Maternal and Child Health

145

### **Breastfeeding Promotion and Support: Peer Counselor Handbook.**

**Form:** Manual.

**Corporate Author:** Virginia Department of Health, Division of Public Health Nutrition, Virginia WIC Peer Counselor Program.

**Source:** Richmond, VA, Virginia Department of Health, Division of Public Health Nutrition, Virginia WIC Peer Counselor Program, 143 p., Revised November 1995.

**Abstract:** This handbook was designed to provide peer counselors with the necessary information and skills to successfully promote breastfeeding in mothers in Virginia's Special Supplemental Nutrition Program for Women, Infants and Children (WIC). The peer counselor (1) offers support and encouragement to pregnant and breastfeeding mothers; (2) provides accurate information about breastfeeding; and (3) helps the mother find answers to her questions, doubts, and fears. The manual contains an orientation for peer counselors and handouts for six lessons. Lesson One, The Human Breast and Lactation, addresses breast changes during pregnancy, common breastfeeding concerns, a diet for breastfeeding mothers, and a WIC-approved food list, and infant nutrition. Lesson 2, Beginning Breastfeeding, discusses the basics of breastfeeding, proper positioning, breast soreness, caring for the baby, the sleepy or fussy baby, and care of the breasts. Lesson Three, Special Situations, includes such topics as illness, drugs, Cesarean delivery, early-onset jaundice, thrush, adolescents and breastfeeding, sex and birth control, nursing more than one baby, breastfeeding during pregnancy, tandem nursing, contraindications to breastfeeding, when to refer to one's supervisor, and support groups. Lesson Four, Mother-Baby Separation,

covers breastfeeding and returning to work or school, breast milk expression, collection and storage, and weaning. Lesson Five, Counseling, discusses counseling skills, telephone counseling, pregnancy counseling, postpartum counseling, a self-assessment counseling checklist, the grief process, cultural beliefs and breastfeeding, and definitions of breastfeeding terms. Lesson Six, Review and Exam, includes a breastfeeding observation guide, a peer counselor referral and contact form, and a monthly report form. Class worksheets and a test are also provided. (HE9700732)

146

### **Breastfeeding Promotion and Support: Peer Counselor Training Manual.**

**Form:** Manual.

**Authors:** Bryan, S.; Burt, A.; Butler, P.; Johnson, D.; Kotula, K.; Morlang, B.; Neville, J.; Tate, M.; White, K.

**Source:** Richmond, VA, Virginia Department of Health, Division of Public Health Nutrition, Virginia WIC Peer Counselor Program, 62 p., Revised March 1996.

**Abstract:** This manual was developed to help trainers provide peer counselors with the information and skills needed to successfully promote breastfeeding in mothers in Virginia's Special Supplemental Nutrition Program for Women, Infants and Children (WIC). The Virginia WIC Peer Counselor Program is designed to (1) recruit more WIC mothers to breastfeed, (2) support WIC mothers who breastfeed and encourage them to do so for a longer time, and (3) help breastfeeding mothers overcome any difficulties they have with breastfeeding. The manual contains an orientation for peer counselors and six lessons. Lesson One, The Human Breast and Lactation,



covers breast anatomy and physiology, breast changes during pregnancy, breast milk, milk composition, advantages of breastfeeding, common myths and barriers, preparing for breastfeeding, and infant and maternal nutrition. Lesson Two, Beginning Breastfeeding, describes the birth process, proper positioning, early problems, growth and development, common concerns, care of the breasts, and the essentials of breastfeeding. Lesson Three, Breastfeeding: Special Situations, includes such topics as contraindications to breastfeeding, nursing more than one baby, breastfeeding during pregnancy, and when to refer a client to a supervisor. Lesson Four, Mother-Baby Separation, addresses breast milk expression, breast milk collection and storage, supplementation, and weaning. Lesson Five, Counseling, discusses the role of the peer counselor, counseling skills, the grief process, cultural beliefs and breastfeeding, and documenting counseling with a referral or contact form and monthly report. Lesson Six, Review and Test, includes a review of previous lessons, an evaluation, a final test and review of the final test, and a format for the graduation ceremony. The manual also includes a monitoring and evaluation section, which describes measures used to evaluate the Peer Counselor Program. Handouts for both trainers and trainees are provided throughout the manual. (HE9700731)

147

### **Can Home Visitation Improve the Health of Women and Children at Environmental Risk?**

**Form:** Journal article.

**Authors:** Olds, D.L.; Kitzman, H.

**Source:** Pediatrics. 86(1):108-116, July 1990.

**Abstract:** Researchers reviewed randomized trials of prenatal and infancy home visitation

programs for socially disadvantaged women and children. Programs recruited women or families that were at environmental risk for maternal and child health problems. The researchers examined three factors regarding home visitation services that are critical in determining success: (1) the underlying causal model of influences on maternal and child outcomes; (2) the corresponding content and structure of the services; and (3) the degree to which the population served was at environmental, behavioral, or psychosocial risk for the particular problem under consideration. Four randomized trials that examined the effect of prenatal home visitation on birthweight and length of gestation were discussed. Researchers also examined 10 trials of home visitation programs that investigated maternal teaching and children's cognitive development as outcomes, 3 trials testing home visitation programs as a means of preventing child abuse and neglect, and 3 trials examining health and other types of psychosocial outcomes. Results of the review suggested that home visit programs with the greatest chance of success have three characteristics: (1) they are based explicitly or implicitly on ecological models, (2) they are designed to address the family ecology during pregnancy and early childbearing years with nurse home visitors who establish a therapeutic alliance with the families and who visit frequently (addressing the systems of behavioral and psychosocial factors that influence maternal and child outcomes), and (3) they target families at greater risk for maternal and child health problems because of poverty and lack of personal and social resources. 40 references. (HE9700490)

148

**Community Health Advocates Training Guidebook.****Form:** Manual.**Corporate Author:** Ohio Department of Health, Commission on Minority Health.**Source:** Columbus, OH, Ohio Commission on Minority Health, 111 p., September 1994.

**Abstract:** Community Health Advocates Training Guidebook is a training book for the Southeast Asian Regional Community Health (SEARCH) Project. The project's goal is to increase the use of maternal and child health services among Cambodian, Chinese, Hmong, Laotian, and Vietnamese refugees and low-income immigrants in Toledo and Columbus, Ohio, and in Detroit, Michigan. SEARCH seeks to reduce informational and logistical barriers to accessing maternal and child health services among the target population and to increase community and provider involvement by improving access to those services through the training of outreach workers and health advocates, outreach, health education, and community-based health services. Part 1 contains trainers' orientation and includes sections on (1) understanding Southeast Asian cultures, (2) cultural orientation, (3) steps for planning the Southeast Asian Community Health Advocate Training program, (4) establishing trust, (5) community resources and assets, (6) selecting community health advocates, (7) learning how adult health workers learn, (8) needs assessment, and (9) an overview of the training model. Part 2 includes training modules: (1) remembering our motherland and cultural heritage; (2) learning to live in the United States; (3) health and illness: two world views; (4) overview of the United States health care system; (5) using health care services; (6) from making an appointment to making payment; (7) avoiding unnecessary use

of the emergency department; (8) women's health issues; and (9) raising healthy children. The training modules were developed after project staff performed a needs assessment at each site. Topics serve as a launching point for the training of any Southeast Asian community members. Each module contains three sections: module overview; outline of instruction; and materials, aids, and references. A reference section includes a resource list, general and cultural references, health belief references, maternal and child health references, mental health references, and lay health workers/advocates/aides references. (HE9700350)

149

**De Madres a Madres: An Access Model for Primary Care.****Form:** Journal article.**Author:** McFarlane, J.**Source:** American Journal of Public Health. 86(6):879-880, June 1996.

**Abstract:** The De Madres a Madres (Mothers to Mothers) program began in 1989 in Houston, Texas, to empower Hispanic American women through unity, to validate women as key health promoters, and to accept the community's ability to identify and meet its own health needs. Neighborhood mothers recruited as volunteers participated in an intensive training program offered by a public health nurse, and worked with her to develop a mission statement and accompanying brochures about community resources for pregnant women. During the second year of the program, the number of volunteers, all of whom were Hispanic and lived in the neighborhood, increased to 20. Volunteer mothers sought out and referred pregnant women to community agencies, including neighborhood clinics, food assistance programs, and social services. They also conducted outreach efforts, accompanied



pregnant women to clinic appointments, and visited the mothers after they had given birth. In return, community citizens and agency personnel identified pregnant women in need of the program and referred them to a volunteer mother. At the end of the second year, a 3-year grant enabled the volunteer mothers to open the De Madres a Madres Center, which was staffed by public health nurses and a volunteer who served as center manager. Programs launched at the center included training in leadership skills, computers, public speaking, and grant writing. In addition, the De Madres a Madres Center was purchased by the volunteer mothers. During the fifth year, the volunteer mothers and lay staff assisted 8,440 persons, a 34 percent increase over the previous year. During the sixth year, additional programs were begun for pregnant adolescents and abused women. The mothers began year 7 (1995) with an operating budget of \$100,000, 6 staff members, and 60 volunteers. Since the beginning of the program in 1989, no low-birthweight infants have been born to women who worked with a volunteer mother. The number of pregnant women followed by volunteer mothers increased from 59 in 1991 to 221 in 1993. The authors conclude that at least 5 years is needed to initiate, develop, and sustain a community-based model for primary care. The involvement and leadership of community residents from the beginning of the program and continuous validation with the community are required, along with local money to ensure local ownership. (HE9600946)

150

### **De Madres a Madres: A Community, Primary Health Care Program Based on Empowerment.**

**Form:** Journal article.

**Authors:** McFarlane, J.; Fehir, J.

**Source:** Health Education Quarterly. 21(3):381-394, Fall 1994.

**Abstract:** The de Madres a Madres (from mothers to mothers) Program began in 1991 in inner-city Hispanic communities in Houston, Texas, to help empower indigenous women through unity, volunteerism, validation of women as key health promoters, and the acceptance of the community's ability to identify and redress its own health needs. Volunteer neighborhood mothers helped pregnant mothers to access prenatal health care. The authors chronicle the 5-year community empowerment process and the collective enhancement of community health. Indigenous volunteer mothers received training in providing information to increase access to health care. Volunteer mothers met and greeted pregnant women and asked about their pregnancy and offered community resource information and a follow-up phone call or home visit. Volunteer mothers also offered information at local stores and banks. By the end of the second year of the program, the volunteer corps grew to 30 mothers, with more than 3,000 women receiving information. In the third year, the program rented a home and hired two community health nurses. In the fourth year, the volunteer mothers formed a coalition with the local health department and other organizations. In the fifth year, the program hired two paid mothers to coordinate outreach and facilitate leadership development. Outcome data have identified the covert functions of the program to be the enhancement



of community self-esteem, power, and economy. 1 table, 17 references. (HE9500083)

151

# **Development of a Paraprofessional Home Visiting Program for Low-Income Mothers and Infants.**

**Form:** Journal article.

**Authors:** Poland, M.L.; Giblin, P.T.; Waller, J.B.; Bayer, I.S.

**Source:** American Journal of Preventive Medicine. 7(4):204-207, July-August 1991.

**Abstract:** Researchers describe the development of a paraprofessional home visiting program that (1) provides services based on empirically documented client needs, (2) uses indigenous paraprofessional maternal and child health advocates, and (3) emphasizes maintaining and enriching the sharing of beliefs, values, and attitudes. To determine client needs, researchers conducted preliminary studies involving (1) telephone interviews with women who received prenatal care in publicly funded clinics, and (2) in-hospital interviews with low-income postpartum mothers. The studies addressed (1) how women evaluate services provided by publicly funded prenatal care clinics in Detroit, Michigan; (2) how to encourage more pregnant women to remain in prenatal care and receive more appointments; and (3) whether prenatal behavior predicts deficits in parenting and therefore makes urgent the continuation of program efforts through infancy. Findings indicates a need for program emphasis in (1) a continuity of services from pregnancy through infancy; (2) the development of needs assessment procedures sensitive to a broad range of health and social problems; (3) an ongoing personal relationship with an indigenous paraprofessional; and (4) a reduction of barriers to prenatal care inherent in the health care system itself (waiting time, lack

of transportation, lack of insurance, lack of available services, and need for a babysitter). Program developers required that advocates (1) receive public assistance, (2) possess a high school diploma or equivalent, (3) live in Detroit, (4) have private transportation, (5) possess qualities of personal warmth, (6) be able to accept full-time employment, and (7) be knowledgeable about the maternal and child health and social systems. The paraprofessional training program fostered mutuality and cooperation and emphasized assertive, caring, and problem-solving behaviors and positive self-esteem. 1 table, 6 references. (HE9200877)

152

# **Effects of Home-Based, Informal Social Support on Child Health.**

**Form:** Journal article.

**Authors:** Dawson, P.; Van Doorninck, W.J.; Robinson, J.L.

**Source:** Journal of Developmental and Behavioral Pediatrics. 10(2):63-67, April 1989.

**Abstract:** Researchers examined the effects of support for parents, through home visits and parent groups, on child health. Participants were (1) recruited from three clinics in a maternity and infant care project of a local health department, (2) expecting their first or second child, (3) 20-26 weeks pregnant, (4) at least 16 years old, and (5) in families with low incomes. Most participants were white (74 percent) or Mexican American (25 percent); one woman was black. Researchers assigned the 175 women to one of three experimental conditions. The control group received routine maternity and pediatric care, including social and nutrition services, occasional home visits by public health nurses, and delivery at the university hospital. Treatment group 1 received the same routine services as the control group

plus weekly home visits. Treatment group 2 received routine services, weekly home visits, and invitations to biweekly parent groups that fostered supportive social interactions among mothers. Home visitors were mothers selected for warmth, empathy, and interest in helping people, with educational levels similar to those of their clients. They received 30 hours of initial training on pregnancy, birth, infant care, safety, nutrition, child development, community resources, and family life. Home visitors developed trusting relationships with clients and focused on emotional support, concrete help, information, and enhancing informal and formal social networks. Researchers used birthweight and gestational age to describe pregnancy outcome. Supervising public health nurses interviewed each home visitor at the end of the project about the families she had visited. Data analysis found (1) no difference between groups in perinatal outcomes for mothers, (2) both women visited at home and control group women made good use of well child care, (3) the greater use of sick child care was concentrated among mothers with moderate or high family stress, and (4) home visitors were more helpful to mothers than to parent groups. 4 tables, 23 references. (HE9700496)

153

### **Guide to Written Training Materials for Home Visitors.**

**Form:** Manual.

**Authors:** Wasik, B.H.; Sheaffer, L.; Pohlman, C.; Baird, T.

**Source:** Chapel Hill, NC, University of North Carolina, Chapel Hill, School of Education, Center for Home Visiting, 59 p., 1996.

**Abstract:** The guide to Written Training Materials for Home Visitors is designed to help educators, program directors, and supervisors of home visitors select materials that can be used

for both preservice instruction and inservice professional development. The manual is divided into three parts. Part 1 reviews 30 written training materials organized into five topic areas: (1) maternal and child health; (2) child abuse, neglect, and injury prevention; (3) early intervention; (4) family support; and (5) health promotion and home health. Materials include training manuals, program manuals, and reference manuals. Each review consists of an abstract that summarizes the background, focus, and format of the material, followed by more specific information about the content, presentation, and literacy level of the material. Part 2 of the manual describes training materials associated with the Parents as Teachers National Center, the Home Instruction Program for Preschool Youngsters (HIPPI USA), and the Elmira Study/Memphis New Mothers/Home Visitation 2000 Program. These materials are not available for general purchase but are integrated with program-sponsored development and training efforts. Part 3 describes books about home visiting and related topics. Descriptions in this section include title, author, format and length, source and year, address, telephone and fax numbers, cost, and a brief summary of the content and target audience of the material. An author index and a title index are provided. (HE9700748)



154

**Healthy Start Initiative: A Community-Driven Approach to Infant Mortality Reduction: Volume I: Consortia Development.**

**Form:** Monograph.

**Author:** McCoy-Thompson, M.

**Source:** Arlington, VA, National Center for Education in Maternal and Child Health, 50 p., 1994.

**Abstract:** Healthy Start Initiative: A Community-Driven Approach to Infant Mortality Reduction: Volume I: Consortia Development is a monograph from the National Center for Education in Maternal and Child Health that describes the challenges the Healthy Start projects have faced in developing consortia and how they handled those challenges. The information was obtained through site visits and interviews with project staff and consortium members at five sites: (1) Baltimore, Maryland; (2) Chicago, Illinois; (3) New Orleans, Louisiana; (4) northwest Indiana; and (5) the Pee Dee region of South Carolina. Chapter 1 introduces the Healthy Start Initiative and its belief that the community, guided by a consortium of individuals and organizations from many sectors, can best design and implement the services needed to meet the needs of that community. Chapter 2 discusses the effects of five critical factors in the development of consortia: (1) the social and political climate, (2) the leadership and participation of the people involved, (3) the availability of financial and human resources, (4) the processes that enable consortium members to work as a team and to handle conflict constructively, and (5) the organizational policies that facilitate or impede collaboration. Chapter 3 describes how the projects responded to four particular challenges in developing consortia: (1) how to create a

suitable framework for management and governance, including how to handle a time-consuming process in a short timeframe, how to divide responsibility, and how to structure the many levels of collaboration; (2) how to increase the participation of consumers, especially adolescents, in Healthy Start; (3) how to resolve tensions caused by racial and class differences; and (4) how to improve economic development in the communities. Chapter 4 discusses future concerns for the Healthy Start consortia and offers recommendations to enhance consortium development. The monograph includes two appendixes, Healthy Start Sites Visited and Bibliography. (HE9700666)

155

**Healthy Start Initiative: A Community-Driven Approach to Infant Mortality Reduction: Volume II: Early Implementation: Lessons Learned.**

**Form:** Monograph.

**Authors:** McCoy-Thompson, M.; Vanneman, J.; Bloom, F.B.; eds.

**Source:** Arlington, VA, National Center for Education in Maternal and Child Health, 86 p., 1994.

**Abstract:** Healthy Start Initiative: A Community-driven Approach to Infant Mortality Reduction: Volume II: Early Implementation: Lessons Learned is a monograph from the National Center for Education in Maternal and Child Health that presents the lessons learned by 15 Healthy Start projects during their first 2 years of planning and implementation, from October 1991 to November 1993. The monograph contains a separate report for each project, describing the unique challenges that were faced at that site and how those challenges were handled. Many of these lessons reflect common themes related



to community involvement, consortia development, management and governance, program initiatives, provider issues, and sustainability. The projects described a variety of methods used to encourage community involvement including (1) recognizing race and class differences, (2) identifying community needs, (3) encouraging participation in program planning, (4) employing community members, and (5) empowering the community to help itself. The projects shared an emphasis on establishing consortia and many described the lessons they had learned in recruiting members and developing effective partnerships with them. They reported several common management and governance issues including the need (1) to prepare well before beginning work, (2) to address funding issues, (3) to implement appropriate personnel policies, and (4) to monitor progress. The projects also described what they had learned from a wide array of program initiatives including outreach programs, integrated services, incentive programs, and efforts to increase male involvement. Many projects shared their concerns and suggestions about how to increase the supply of medical providers, facilitate linkages among providers, and work directly with providers. Several projects described their efforts to establish interventions that could be sustained and be replicated in other communities. (HE9700667)

156

### **Healthy Start Initiative: A Community-Driven Approach to Infant Mortality Reduction: Volume III: Sustainability.**

**Form:** Monograph.

**Authors:** McCann, T.; Young, B.W.; Hutten, D.; Lightsey, D.; McCoy-Thompson, M.; Cox, S.; Dirladian, A.; eds.

**Source:** Arlington, VA, National Center for Education in Maternal and Child Health, 106 p., 1995.

**Abstract:** Healthy Start Initiative: A Community-Driven Approach to Infant Mortality Reduction: Volume III: Sustainability is a monograph from the National Center for Education in Maternal and Child Health that describes strategies the Healthy Start projects can use to sustain their work beyond the initial 5-year funding period. The monograph is intended for both existing Healthy Start sites and consortia and other communities that wish to adopt the Healthy Start philosophy. It describes how the demonstration sites can empower their own community-based initiatives to continue over the long term and how they can help other communities to replicate their successes. The monograph focuses on three approaches to sustainability: (1) capitalizing on a changing environment, (2) telling the Healthy Start stories, and (3) building bridges to public and private resources. Chapter 1 describes how the Healthy Start projects can capitalize on changes in the local, state, and federal environments to take advantage of new opportunities and plan effectively for the future. Chapter 2 discusses the importance of telling the stories of each Healthy Start site in terms of its effect at the community level. It provides information about the methods used and the lessons learned in evaluating several common Healthy Start components: (1) economic development and

empowerment, (2) support services, (3) consortia and governance, (4) public information and education, and (5) preventive services for adolescents. Chapter 3 describes how the Healthy Start sites can build capacity for sustainability by (1) building partnerships with community stakeholders, including government agencies, health care providers, businesses, community-based organizations, and consumers; (2) building bridges to public and private financial resources; and (3) building networks and sharing information with each other. (HE9700668)

157

**Healthy Start Initiative: A Community-Driven Approach to Infant Mortality Reduction: Volume IV: Community Outreach.**

**Form:** Monograph.

**Authors:** McCann, T.; Young, B.W.; Hutten, D.; Hayes, A.; Wright, B.; Lightsey, D.; Gwinner, V.; eds.

**Source:** Arlington, VA, National Center for Education in Maternal and Child Health, 148 p., 1996.

**Abstract:** Healthy Start Initiative: A Community-Driven Approach to Infant Mortality Reduction: Volume IV: Community Outreach is a monograph from the National Center for Education in Maternal and Child Health that offers suggestions to improve community outreach services. The monograph is intended for three audiences: (1) the community health workers who provide outreach services; (2) the programs that recruit, train, and supervise outreach workers; and (3) other health care providers, agencies, and policy makers. Chapter 1 presents suggestions for outreach workers on (1) how to improve services to clients, (2) how to encourage fathers' involvement, (3) how to better serve

ethnically diverse populations, and (4) how to care for their own needs as they reach out to others. Chapter 2 offers suggestions for outreach programs about (1) how to define the roles of outreach workers; (2) how to recruit, train, and supervise outreach workers; and (3) how to develop networks and support groups to enhance communication about outreach workers. Chapter 3 suggests strategies (1) for building and maintaining partnerships between outreach programs and other community resources, (2) for working together to sustain outreach programs, (3) for working with managed care organizations, and (4) for working with policymakers. Chapter 4 describes how to design responsive training materials and home visiting activities, based on needs assessments and how to collect data and evaluate programs. The chapter also explains how computerized information systems can improve services to clients and how research can benefit home visiting and outreach worker programs. The final chapter describes how three model programs use perinatal outreach workers as a critical part of their efforts to reduce infant mortality and improve family health. An appendix describes several resources for fundraising and sustainability. (HE9700669)

158

**Healthy Start Initiative: A Community-Driven Approach to Infant Mortality Reduction. Volume V: Collaboration With Managed Care Organizations.**

**Form:** Monograph.

**Authors:** Joffe, M.S.; Back, K.

**Source:** Arlington, VA, National Center for Education in Maternal and Child Health, 115 p., 1997.

**Abstract:** The Healthy Start Initiative: A Community-Driven Approach to Infant



Mortality Reduction, Volume V, Collaboration With Managed Care Organizations, is a manual to assist Healthy Start projects and their subcontracting service providers in developing proposals and entering into contracts with health maintenance organizations (HMO's) that serve Medicaid clients. The manual is intended to help these organizations (1) understand and evaluate the needs and responsibilities of HMO's, (2) evaluate and adapt their own capabilities and those of their subcontractors to meet the HMO's needs, (3) develop and market proposals, and (4) successfully negotiate contracts with HMO's. Chapter 1 reviews some of the initial steps in pursuing relationships with Medicaid managed care programs. Chapter 2 provides basic information about the characteristics and types of HMO's, HMO providers, and provider payment arrangements. Chapter 3 explains the benefits of contacting the state's Medicaid managed care program. Chapter 4 explores factors influencing an HMO's willingness to contract with a Healthy Start project. Chapter 5 describes four broad strategies the Healthy Start project can use to enhance its attractiveness to HMO's: demonstrating that the Healthy Start project can help the HMO provide required services, performing well on quality measures, reducing costs, and increasing revenues. Chapter 6 describes the steps involved in preparing to act as a contractor to HMO's. Chapter 7 discusses the process of deciding what services to offer to HMO's. Chapter 8 explains how to develop and market a managed care proposal. Chapter 9 describes how to propose and negotiate a contract. Chapter 10 addresses issues that may arise while working with an HMO. The appendixes include a glossary of managed care terms, sample HMO-Healthy Start project contracts (detailed and short versions), a sample Healthy Start project subcontractor agreement,

a list of state Medicaid directors, and a list of state Maternal and Child Health contacts. (HE9701200)

159

### Home Health Visiting in Europe.

**Form:** Journal article.

**Authors:** Kamerman, S.B.; Kahn, A.J.

**Source:** *Future of Children*. 3(3):39-52, Winter 1993.

**Abstract:** The authors discuss home health visiting in Europe. European home health visiting services differ in many ways with the services of those programs in the United States. Most notably, the programs are largely universal, (e.g., the services are offered to all families). They have existed in Europe for more than a century and are a well-accepted part of life that is integrated into broad government-funded health and social services. The programs are popular, generously supported, and viewed as effective. Special attention in this article is given to describing home visiting programs in Great Britain (England, Scotland, and Wales) and Denmark. Each of the countries believes that home health visiting programs are one piece of an essential network of economic and social supports provided by the government to families. Achievement of child health goals requires not only health services, but also cash and noncash benefits, housing supports, child care services, and social services as needed by the family. In each of the countries researched, home visiting programs are voluntary, free, and not income-tested. They are carried out by professionals, usually registered nurses, who visit homes following the birth of a child. They provide health education, preventive care, and social support services to very young children and their parents. The services are supplemented by more comprehensive health services available



to children through a system of maternal and child health clinics or private doctors under a universal health insurance system. European home health visiting programs differ in many ways including (1) whether special focus is given to specially identified families, (2) whether a family is visited after the birth of their first child only, (3) whether visits begin prenatally, (4) whether the visits are supplemented with center-based support groups and care, and (5) the frequency of the visits. The services described contrast greatly with the services of those programs in the United States. The authors address a pointed question: Could this be replicated in the United States? They conclude that a truly effective home health visiting program could not be possible without a comprehensive maternal and child health delivery system and national health insurance. The United States lacks such an infrastructure. The authors also suggest that the United States has little experience with universal programs, a key characteristic of European programs and central to their success. 12 references. (HE9700604)

160

### **Home Visitation for Pregnant Women and Parents of Young Children.**

**Form:** Journal article.

**Author:** Olds, D.L.

**Source:** American Journal of Diseases of Children. 146(6):704-708, June 1992.

**Abstract:** A researcher synthesized research on home visitation for pregnant women and parents of young children and examined current legislative initiatives in light of that research. The design and results of a randomized trial of prenatal and infancy home visitation by nurses carried out in Elmira, New York were reviewed. Evidence from other randomized trials was also examined and analyzed in relation to the

proposals of major advisory groups and current legislative initiatives. The Elmira study involved 400 women who were having their first child and were at risk for poor pregnancy and health outcomes because they were poor, unmarried, or teenagers. Results of the study showed that home visitation participants had more improved outcomes than the other participants. A review of all the randomized trials of pregnancy and infancy home visitation programs showed that programs varied tremendously in terms of objectives, target groups, structure, background of visitors, and corresponding effectiveness. More successful programs focused on families at greater need for services; they used nurses who visited frequently, beginning during pregnancy and continuing at least through the second year of the child's life. These programs were based on comprehensive service models. The researcher noted few of the legislative initiatives before Congress or other home visitation proposals contain all of the programmatic features needed for program success and recommended developing a national home visitation program for parents and young children. 1 figure, 1 table, 29 references. (HE9700493)

161

### **Home Visiting: Analysis and Recommendations.**

**Form:** Journal article.

**Authors:** Gomby, D.S.; Larson, C.S.; Lewit, E.M.; Behrman, R.E.

**Source:** Future of Children. 3(3):6-22, Winter 1993.

**Abstract:** The authors analyze home visiting and provide recommendations for improving the practice. Home visiting programs are more popular today than ever before, providing information, health care, and psychological or other support services directly to families.

These programs can (1) reach those who otherwise might not receive services, (2) connect families with other services in the community, and (3) foster special relationships between the visitor and the family. There is a broad range of health or social service home visiting programs in the United States, however there is no uniformity in these programs. Research has shown that home visiting programs show diversity in (1) the goals of the programs, (2) the experience and backgrounds of their staff and their clients, (3) the intensity and duration of the services they provide, and (4) the extent to which home visiting is the primary service provided. It is the diversity of families that produces the enormous challenges these programs face in meeting their needs. Research focusing on the evaluations of experimental designs of programs for pregnant women or families with young children have shown that the most significant benefits have been achieved in home visiting programs that attempt to address a broad array of the needs of both children and their parents. They focus on the cognitive development of the child as well as address many aspects of child health and development and the needs of the family for emotional and material support. Benefits have largely been achieved through child development outcomes and, to a lesser extent, through health outcomes. Some of the largest gains have been achieved in programs where home visiting is not the only strategy, but is augmented by other services and programs. A review of characteristics of successful programs shows that home visiting programs should be (1) voluntary, (2) flexible, (3) culturally sensitive, (4) well-staffed, and (5) realistic to the expectations of the program staff and the community. Costs of home visiting programs vary, depending on several factors including (1) number and duration of visits, (2) home visitor case load, (3) home visitor credentials, (4) supervision and administration of visitors, and

(5) parent time. Much work needs to be done in the economic analysis of home visiting programs. The author concludes that although home visitors can improve children's health and development in important ways, these gains cannot continue without ongoing comprehensive support for children and families. Evidence for the effectiveness of home visiting programs is as good or better than the evidence for the effectiveness of many other programs that exist to serve children and families. 45 references. (HE9700602)

162

### **Home Visiting and Prenatal Care: A Survey of Practical Wisdom.**

**Form:** Journal article.

**Authors:** Peoples-Sheps, M.D.; Efird, C.; Miller, C.A.

**Source:** Public Health Nursing. 6(2):74-79, June 1989.

**Abstract:** Researchers surveyed experts in prenatal care to determine their perceptions about the value of selected strategies for encouraging participation in care, for education, and for behavior change, with particular emphasis on home visiting. Respondents were 118 individuals with experience in organizing and implementing prenatal care programs for poor women or other high-risk groups, who were recommended by directors of official maternal and child health programs. The respondents represented 48 states, 49.2 percent were nurses, and 51.7 percent were over 40 years old. Each person received a mailed nine-page questionnaire requesting information on strategies for promoting early and continuous prenatal care and education and behavior change during the prenatal period. The questionnaire identified 10 strategies in each area and requested that respondents indicate whether or not they had experience with them



and the extent to which they perceived each one to be effective. Data analysis found important discrepancies between respondents' perceptions about the effectiveness of some prenatal strategies and the actual extent of their use in practice. The findings suggest that home visiting is considered highly effective in three of the purposes explored: (1) promoting early registration for care, (2) educating women during pregnancy, and (3) influencing appropriate changes in behavior. Peer counselors were considered to be the most effective for educational purposes. Counseling by paraprofessionals was viewed as moderately effective in educational efforts, but most effective for altering unhealthy behaviors. The results raised questions about the education and background of home visitors and the appropriate role for public health nurses. 5 tables, 17 references. (HE9700488)

163

### **Home Visiting Programs and the Health and Development of Young Children.**

**Form:** Journal article.

**Authors:** Ramey, C.T.; Ramey, S.L.

**Source:** *Future of Children*. 3(3):129-139, Winter 1993.

**Abstract:** The authors present a conceptual framework for understanding and describing the modes of operation of home visiting programs and the specific areas of early childhood health and development they address. The first 3 years of a child's life represent the period of the most rapid growth and development, especially in terms of central nervous system development and associated physical development and social behavior. Therefore, home visiting programs during this period of development can and often do have goals of both enrichment and prevention. Additionally, children's health and development include eight distinct, but

interdependent, domains of functioning: (1) survival; (2) values and goals; (3) a sense of security; (4) health; (5) social interaction; (6) self-esteem; (7) communication; and (8) basic intellectual skills. Most home visiting programs place some emphasis on one or more of these eight domains, with the assumption that once the most urgent family issues have been resolved satisfactorily, other less pressing but important aspects of young children's health and development can be addressed. The authors find evidence that programs which target for change only one or a few areas of functioning are not likely to have a lasting beneficial effect, even on the targeted aspects. To be successful, home visiting programs must be comprehensive in their approach to addressing children's and families' needs in multiple domains of functioning. The authors conclude with an analytical grid that can be used to describe and clarify the relationships among the characteristics of home visiting programs and their desired consequences. The appendix offers an application of the grid to describe the Infant Health and Development Program. 2 figures, 11 references. (HE9700608)

164

### **Home Visiting Programs for Families With Children Birth to Three: Results of a National Survey.**

**Form:** Journal article.

**Authors:** Roberts, R.N.; Wasik, B.H.

**Source:** *Journal of Early Intervention*. 14(3):274-284, 1990.

**Abstract:** Researchers conducted a national survey to document the wide range of home visiting prevention services provided to families through public and private health, education, and social services. They developed a 430-variable, 13-page questionnaire that surveyed



(1) program affiliation, (2) population served, (3) child and parent characteristics, (4) purposes of the program for parents and children, (5) coordination of services for free-standing and combined programs, (6) funding, (7) specific home visiting services provided, (8) delivery models for home visits, (9) curriculum for home visiting services, (10) home visitor employment and training, (11) supervision of home visitors, and (12) evaluation strategies. Researchers analyzed the responses of 643 programs that exclusively served families with children from birth to 3 years. Results of the survey reported (1) types of agencies that employ visiting for that age range, (2) types of families that receive home visiting services, (3) purposes for which home visits are conducted, (4) services provided to families, (5) organizational structures of home visiting programs, and (6) educational levels required of home visitors and their supervisors. Findings indicated that there is a network within communities that provides home-based services to children from birth to 3 years. These services are provided by health, education, and social service programs, though health and education are the predominant providers of service. Most programs used some combination of professional and paraprofessional home visitors in providing services to the families. Services are provided by individuals who have a relatively large amount of professional training (very few paraprofessionals). Programs have set minimum educational requirements consistent with the types of services they provide. Programs report that home visitors do not carry excessive case loads. Most programs have some form of evaluation of their clients and programs. 7 tables, 22 references. (HE9700489)

165

### **Home Visiting With Families in Poverty: Introducing the Concept of Culture.**

**Form:** Journal article.

**Author:** Slaughter-Defoe, D.T.

**Source:** *Future of Children*. 3(3):172-183, Winter 1993.

**Abstract:** The author asserts that contemporary child and family intervention programs too frequently neglect the cultural context in which programs are introduced. The problems of high case loads, scarce resources, and little or no attention to cultural context all too often characterize both prevention and treatment programs. Home visitors do not have the time, resources, or mission to assess carefully the adaptive strengths and cultural ecology of participating children and families. This assertion is illustrated with a discussion of the State of Illinois Department of Child and Family Services program, which is offered as an example of a home visiting program used inappropriately. The author argues that comprehensive service programs are what is needed today, with program design and development taking into account the cultural ecology of the participants including their geographical, historical, and contemporary behavioral patterns. Four steps that are important in designing culturally appropriate services are identified: (1) assess cultural context of the program; (2) establish and encourage an open dialogue regarding program goals; (3) consider the culture of the program staff; and (4) consider alternative program formats, such as group- and center-based care. The author illustrates the use of these steps with reference to some cultural characteristics of African American families, and stresses that similar consideration of the characteristics of other racial and ethnic groups is essential when planning their services. The author concludes

by stating that home visiting as a social support strategy is worthy of close scrutiny. However, the strategy is often used with little or no thought to cultural considerations.

42 references. (HE9700610)

166

### **Home Visits: Necessary But Not Sufficient.**

**Form:** Journal article.

**Author:** Weiss, H.B.

**Source:** *Future of Children*. 3(3):113-128, Winter 1993.

**Abstract:** The author discusses the argument that home visits are a necessary, but not sufficient, component of a larger national strategy to strengthen families and improve the health, well-being, and positive life chance of poor children. The author first offers a brief examination of the pertinent lessons about the strengths and limits of home visit strategies learned from America's first major effort to provide home visits to poor families more than 100 years ago. In the second section of the article, the evidence and experience from more contemporary programs are examined to test the notion that home visits are a necessary component of a system of services to reach and serve disadvantaged families. The premise from which these modern programs work is that in order to foster the early development of children, especially disadvantaged ones, it is necessary to intervene at home with parents to support and improve socialization, health, and education practices. Some of these programs rely on home visits as the exclusive means of intervention, while others include them with other services. Additionally, a study of home visit programs shows considerable variation in initiative on many factors, including goals, content, timing, duration, and visitor and client characteristics. There are, however, special features of home visiting programs that help to

make them effective and successful, such as (1) regular and frequent visits beginning in the prenatal period and continuing for the first 2 or more years after birth, (2) a core educational program and communication strategy designed to be responsive to parent needs, and (3) a broadening of content and goals to include attention to a wider range of psychosocial and economic obstacles to healthy development and family functioning. In section three, the author suggests why home visits alone are insufficient. Studies of home visit implementation show that the visitor often uncovers family needs beyond those related narrowly to the program focus.

The home visiting program becomes less effective when there is a failure to provide the needed information and attention. The fourth section discusses the difficult question of how to develop a home visiting initiative that is feasible and that helps to build a sufficient system of family support services to improve the health, well-being, and life chances of all, but especially of poor children and families. Finally, the author lays out a preliminary plan for a new home visiting initiative that is a catalyst for a broader system of services. A preliminary plan for national home visiting legislation is outlined. 63 references.

(HE9700607)

167

### **Homeless Prenatal Program: A Model for Empowering Homeless Pregnant Women.**

**Form:** Journal article.

**Authors:** Ovrebo, B.; Ryan, M.; Jackson, K.; Hutchinson, K.

**Source:** *Health Education Quarterly*. 21(2):187-198, Summer 1994.

**Abstract:** The Homeless Prenatal Program (HPP) is one of the first programs in the country to provide comprehensive prenatal services to homeless pregnant women. The



HPP was established in a San Francisco, California, family shelter in 1989 to improve birth outcomes and assist homeless women in transforming their lives. The HPP ascribes to a model of empowerment that is both behavioral and structural as women are empowered to have healthy birth outcomes and change their life circumstances. HPP provides clients with case management, peer support, and advocacy. The multifaceted staff consists of social workers, nurses, and community health outreach workers. The main vehicle of empowerment is the outreach worker support group in which homeless women share experiences and engage in honest dialogue in a safe environment. In HPP's service model, empowerment has two central tenets: (1) the mother-child connection and (2) the principle of giving back (to other homeless mothers what the community health outreach workers themselves once needed and received). Although exit from the program can occur at any point, women are invited to stay with the program as long as they wish, to continue attending support group meetings, to receive counseling, and to participate in family planning services. Researchers conducted a formative evaluation in 1992 to measure the program's effectiveness in improving neonatal outcomes, model of service delivery, and community impact. Quantitative measures assessed neonatal outcomes and short-term effects through internal and external comparisons of existing records of HPP clients and county birth records. The qualitative aspect of the evaluation used participant observation to document the processes of the support groups, outreach work, and clinic appointments and semistructured interviews with the HPP staff to explore the program's organizational structure, and to identify services provided by the HPP and assess the staff's understanding of the clients' needs and experiences. Program records of current and former clients were analyzed to determine the client's demographic

characteristics, health status, and services received. The records of 214 clients were analyzed, revealing that the typical HPP client (1) is African American, age 27, with one or more children; (2) enters HPP during her second trimester of pregnancy; and (3) has had no prior prenatal care. Evaluation results indicated that HPP is achieving its program goals. 1 figure, 37 references. (HE9400793)

168

### **Immunizing America's Children: A Model Workshop.**

**Form:** Information package.

**Corporate Author:** Healthy Mothers, Healthy Babies Coalition, Immunization Education and Action Committee.

**Source:** Washington, DC, Healthy Mothers, Healthy Babies Coalition, Immunization Education and Action Committee. 13-page manual and 9 tip sheets, n.d.

**Abstract:** Immunizing America's Children: A Model Workshop is designed to help health educators highlight and enhance the effect of existing immunization efforts in educating the community about childhood immunizations. The overriding theme of the workshop is that a single intervention is unlikely to lead to a sustained, long-term improvement in immunization rates. Rather, a collaborative effort by public health departments, private physicians, hospitals, day care centers, pediatric nurses, civic groups, policymakers, and others would be necessary to achieve the United States' immunization goals by 1996. The workshop model provides an opportunity for the exchange of innovative ideas and strategies for increasing access, reducing barriers, forming partnerships, and sharing information. The workshop can help increase awareness of age-appropriate immunization, enhance existing partnerships, and attract new partners who can



participate in long-term education efforts. This publication contains background materials and includes a sample task list, invitation, agenda, and press release. It provides recommendations to maternal and child health programs that can be tailored to a specific community's needs. (HE9700467)

169

### **Inside Home Visiting Programs.**

**Form:** Journal article.

**Author:** Powell, D.R.

**Source:** *Future of Children*. 3(3):23-38, Winter 1993.

**Abstract:** The author discusses the wide variation that exists among home visiting programs in their content, theory, and operation. Several current programs are discussed to illustrate different home visiting dimensions and approaches. Programs focus on parents of young children from pregnancy through age 6 years; the programs represent the differences among populations served as well as the differences among approaches to home visiting. Several variables influence the underlying theory for home visiting programs: (1) the specification of goals and outcomes; (2) assumptions, such as family resourcefulness and determinants of behavior; (3) strategies for effective change in individuals; and (4) the sponsoring agency. Home visiting programs vary not only in their theoretical and organizational content but also in the specifics of their operation, particularly in four areas: (1) the content or focus of the home visit, (2) the intensity of the program, (3) the mechanisms for responding to specific parent and child needs, and (4) the staffing patterns. The author notes that only one program, the Mother-Child Home Program, has been evaluated by employing the rigorous technique of random assignment. However, the key

elements of program design outlined are useful in conceptualizing potential or analyzing existing evaluations. The author does not draw conclusions as to which approaches may be more effective than others in achieving positive results, but does agree that some programs appear to better serve particular populations. The decisions about program methods should be driven by the needs and characteristics of the target population. The author concludes that home visiting is not a uniform practice but is a richly textured and highly varied service delivery method whose effectiveness differs across settings and populations just as much as its design. 1 table, 37 references. (HE9700603)

170

### **Mobile Van Programs That Provide Immunization Services: A Compendium of Programs.**

**Form:** Directory.

**Corporate Author:** Healthy Mothers, Healthy Babies Coalition, Immunization Education and Action Committee.

**Source:** Washington, DC, Healthy Mothers, Healthy Babies Coalition, Immunization Education and Action Committee.

132 p., April 1996.

**Abstract:** This directory is a reference of existing mobile van programs and a resource for those considering starting a program. The directory is organized as a state-by-state summary of mobile van programs throughout the United States. The National Center for Education in Maternal and Child Health surveyed the mobile van programs on: (1) whom they serve, (2) what services they provide, (3) who sponsors the programs, (4) what tracking systems are used (if any), and (5) what parent and professional educational materials are used. The guide answers the questions: (1) if you were looking to purchase

another van, what features would be most useful? and (2) what resources would effectively eliminate the need for your program? The Immunization Education and Action Committee of the Healthy Mothers, Healthy Babies Coalition encourages the reader to use this directory as a reference when working with existing programs or as a resource if beginning a program. (HE9700466)

171

### **Model Program for Providing Health Services for Migrant Farmworker Mothers and Children.**

**Form:** Journal article.

**Authors:** Watkins, E.L.; Larson, K.; Harlan, C.; Young, S.

**Source:** Public Health Reports. 105(6): 567-575, November-December 1990.

**Abstract:** The School of Public Health of the University of North Carolina at Chapel Hill developed a collaborative effort to assist the Tri-County Community Health Center in improving the health of migrant mothers and children and to use the educational and consultant services of the state's Title V. Researchers describe the project and discuss (1) sociodemographic characteristics of the maternal and child population of migrant and seasonal farmworkers who work in North Carolina and received primary care services at the Tri-County Community Health Center between April 1985 and October 1987, (2) their health status indicators, and (3) trends in service use. Participants were 359 pregnant farmworkers and 560 children ages birth through 5 years. More than half of the women were Hispanic and almost all of the white women were married to Hispanic men. The total group of pregnant farmworkers had a mean age of 23.1 years, and 47 percent had completed 8 or fewer years of education. The health problems

reported most frequently for the women during their pregnancy were urinary tract infections (23 percent) and sexually transmitted diseases (7 percent). Eighty-four percent of the participants had dietary recalls showing calorie intakes of under 90 percent of the recommended dietary allowance. Of the 318 participants for whom pregnancy outcome data were available, 286 had live births; 8.4 percent had low birthweight infants. A Spanish-speaking staff of two public health nurses, a public health nutritionist, and a social worker developed a tracking system to encourage participants to maintain their health care after they left the center's service area. The project staff primary interventions included outreach and early case finding, coordination between the center's programs and other health and social service agencies, and a health education program conducted to train migrant farmworker women as lay health advisors. Project activities included designing a nutrient scoring system of the participants' diets and presenting a series of classes in English, Spanish, and Haitian-Creole on appropriate health practices and the use of health and social services to migrant farmworker women recruited as lay health advisors. Classes were scheduled at locations convenient to the migrant farmworkers' residences (e.g., labor camps, church facilities, and the Migrant Head Start Center). Forty-two women completed the lay health advisor training program, 10 of whom participated for more than one season. To promote continuity of care, migrant farmworker women and children received copies of their health records on the first visit, together with stamped postcards to notify center staff of their new location when they moved. During 1986 and 1987, (1) the number of children with complete immunizations rose from 41 percent to more than 60 percent, (2) more than 75 percent of the children received a developmental screening, (3) more women initiated care in the first



trimester of pregnancy and made nine or more prenatal care visits, (4) the proportion of women breastfeeding their newborns increased from 31 percent to 52 percent, and (5) there was a significant decrease in the mean number of visits to the health center among infants, from 4.5 visits to 3.1. The project demonstrated how establishment of communication between the two systems of care, the migrant health center and the Title V maternal and child health programs, enriched the services available to migrant farmworker women and children and improved their health status. 9 tables, 22 references. (HE9700092)

172  
**Nike-Footed Health Workers Deal With the Problems of Adolescent Pregnancy.**

**Form:** Journal article.

**Author:** Perino, S.S.

**Source:** Public Health Reports. 107(2): 208-212, March-April 1992.

**Abstract:** The proposed Nike-Footed Health Worker Project (NFHW) seeks to train adolescent mothers to become home-visiting health workers in their own community. Project objectives are (1) to graduate 25 young mothers with a high school diploma and training necessary to provide prenatal and postnatal health care, teach parenting skills, and counsel pregnant and parenting adolescents; (2) to assign the NFHW's to jobs within a private or government agency, each with a minimum caseload of 10 pregnant or parenting adolescents; and (3) to receive loan repayments regularly from each NFHW. The adolescent mothers will complete high school while they are simultaneously trained in the principles of basic prenatal and postnatal care, child development, nutrition, and counseling. The residential project's enrollees will spend 8 hours a day, 5 days a week in training; for one-

half of each day, they will work toward earning their high school diploma; for the other half, they will fulfill requirements necessary to become an NFHW. After 1 year, they will return to their own communities to serve that population. After signing a contract, trainees will begin the project and receive a base salary in the form of a student loan. Eligible for merit wage increases, they must use their salaries to make preset contributions to the project for housing, food, and child care expenses. Upon graduation, NFHW's will work out of local clinics and hospitals to bring basic care to the homes of pregnant teenagers. Although not associated with the Nike Corporation, project health workers will wear the popular sneakers (1) to emphasize that their services are mobile and accessible and that health need not be confined within clinic walls and (2) to associate themselves with Nike's advertising slogan, Just Do It. NFHW's will help prepare expectant mothers for the arrival of their infant and will continue to work with the mother and her primary health care providers as the new mother learns how to parent. 1 table, 7 references. (HE9201397)

173  
**Prenatal Education Outcomes for Pregnant Adolescents and Their Infants Using Trained Volunteers.**

**Form:** Journal article.

**Authors:** Jones, M.E.; Mondy, L.W.

**Source:** Journal of Adolescent Health Care. 11(5):437-444, September 1990.

**Abstract:** A study evaluated the effects of lessons taught by trained nonprofessional volunteers to pregnant adolescents in community prenatal clinics. The Serving Pregnant and Parenting Adolescents' Needs (SPPAN) project trained nonprofessional volunteers to serve as teachers of prenatal



lessons to low income pregnant adolescents and as postpartum hospital visitors to adolescent mothers. The study compared SPPAN project participants with nonproject comparison subjects on the number of prenatal visits; return rate for postpartum care, family planning follow up and annual visit; return for a well-child visit within the first postpartum year; return to school following delivery; number of child abuse/neglect reports; and the rate of repeat births within 2 years of the index birth. The study population included 210 participants and 189 comparison subjects aged 18 years or younger attending the same hospital in Dallas County, Texas. The study divided participants into high or low treatment groups according to attendance; the high treatment group subjects participated in eight or more lessons. The project used a system of rewards for attendance at each session and at the postpartum visit. Researchers collected data on the participants from clinic, hospital, and school district records. Results of data analysis and log linear modeling techniques suggest that a prenatal education program of lessons taught by trained nonprofessional volunteers as an adjunct to well-administered medical care can affect short-term compliance with health regimens in ways similar to more comprehensive and expensive intervention programs. 4 tables, 18 references. (HE9100289)

174

### **Review of Research on Home Visiting for Pregnant Women and Parents of Young Children.**

**Form:** Journal article.

**Authors:** Olds, D.L.; Kitzman, H.

**Source:** *Future of Children*. 3(3):53-92, Winter 1993.

**Abstract:** The authors review the results of literature concerning the effectiveness of home

visiting programs in improving the lives of children and families. Their review concentrates on randomized trials of home visiting programs aimed at reducing the rates of preterm delivery and low birthweight, and promoting the health and development of parents and young children. The review includes results of 31 home visiting programs that have focused on: (1) preventing preterm delivery and low birthweight, (2) improving the health and development of low birthweight or preterm infants and their parents, (3) enhancing the well-being of children from families at social or economic risk, (4) families in which the child has a developmental disability or chronic disease, and (5) costs and savings that result from averted use of other services and increases in government tax revenues resulting from improvements in parent and child well-being. Outcomes of the programs are discussed including (1) changes in parental behavior, home environment, child development and behavior; (2) child abuse; (3) rates of preterm and low birthweight births; and (4) health care use. The authors found that narrowly focused home visiting programs did not take advantage of many opportunities for the promotion of numerous aspects of maternal, child, and family health. The evidence suggests that these programs were less successful. Results suggest that home visiting programs in the past have benefitted some families but not others, and have improved some outcomes but all outcomes. These differences may be the result of several characteristics of the home visiting programs including their comprehensiveness of purpose and goals, level of staffing, frequency of visits, and the populations they are designed to serve. Also, many of the studies failed to measure what the programs tried to affect. The authors conclude that programs that (1) are comprehensive in focus, (2) have frequent visits, (3) are staffed by well-trained professionals, and (4) serve families that are

initially at increased risk for poor outcomes are more likely to demonstrate success. 4 tables, 68 references. (HE9700605)

175

### **Staffing Issues for Home Visiting Programs.**

**Form:** Journal article.

**Author:** Wasik, B.H.

**Source:** Future of Children. 3(3):140-157, Winter 1993.

**Abstract:** The author outlines some of the critical considerations for the recruitment, training, and support of home visitors, and offers guidelines concerning the staffing of home visiting programs. A historical review of home visiting indicates that the roles of home visitors have shifted as philosophy and beliefs about human services have changed. Over time, new responsibilities have been created for home visitors. Program designers and administrators need to consider five important issues to develop a quality program staff: (1) professional experience or education; (2) race, ethnicity, and culture; (3) experience, age, and maturity; (4) sex; and (5) interpersonal and helping skills. Administrators must also consider the training needs for home visitors, the supervision and support in addition to training that home visitors need after they are hired, and the implications of sometimes stressful working conditions for staff turnover. However, the most important criterion is a candidate's initial level of interpersonal and communication skills. The author concludes that to make good staffing decisions, programs should first determine what their specific goals and objectives are and then decide what knowledge and skills the home visitors must have to meet those goals and objectives. 1 table, 50 references. (HE9700609)

176

### **Strengthening the Community: The Emerging Role of Outreach: A Manual for Outreach Workers.**

**Form:** Manual.

**Corporate Author:** Ohio Department of Health, Ohio Infant Mortality Reduction Initiatives Program.

**Source:** Columbus, OH, Ohio Department of Health, Ohio Infant Mortality Reduction Initiatives Program, 124 p., September 1996.

**Abstract:** The Ohio Department of Health, Ohio Infant Mortality Reduction Initiatives Program (OIMRI). OIMRI is a federally funded program that aims to reduce infant mortality by improving birth outcomes and promoting infant health. Currently, the Ohio Department of Health Funds 14 local projects to identify and recruit into care the most at-risk pregnant women, and to follow them through their pregnancy, postpartum period, and the infant's first year of life. The outreach concept has been traditionally used as an approach to providing prenatal and other health care services to the most at-risk pregnant women. This approach involves door-to-door canvassing, needs assessment, care planning, referrals, and home visiting. This manual is a guide on how to carry out an outreach and home visiting project. Subjects covered in the manual include (1) overview of pregnancy, (2) canvassing and safety skills, (3) contraceptives and sexually transmitted diseases, (4) substance abuse during pregnancy, (5) case management and accountability, (6) home visiting: how and when, and (7) the first year of life: well child and immunizations. (HE9700469)



177

**Universal Home Visiting: A Recommendation From the U.S. Advisory Board on Child Abuse and Neglect.**

**Form:** Journal article.

**Author:** Krugman, R.D.

**Source:** Future of Children. 3(3):184-191, Winter 1993.

**Abstract:** In 1991, the United States Advisory Board on Child Abuse and Neglect recommended that the federal government implement a new initiative to phase in universal voluntary home visiting for children during the neonatal period to help prevent child abuse and neglect in the United States. According to the author, the 15-member Board's recommendation for home visiting was shaped by (1) Dr. David Olds' promising research findings regarding home visiting, (2) communications with providers of home visiting services around the country, and (3) the Board members' intuitive belief that home visiting makes good sense. Five options for action were included in the Board's recommendation: (1) launch pilot projects, (2) direct appropriate sections of the Department of Health and Human Services (DHHS) to stimulate the development of volunteer programs, (3) direct appropriate sections of the DHHS to attempt to persuade insurers to cover the costs of home visiting, (4) direct the Assistant Secretary for Health to ensure that home visiting services are provided through the health care programs of the Indian Health Service, and (5) direct the Assistant Secretary for Health to attempt to persuade the Department of Defense to provide home visiting services to military families. 10 references. (HE9700611)

178

**Using Health Education Aides in Counseling Pregnant Women.**

**Form:** Journal article.

**Author:** Conn, R.H.

**Source:** Public Health Reports. 83(11):979-982, November 1968.

**Abstract:** A health educator discusses the use of health education aides in counseling pregnant women. In 1966, the Health Education and Information Department of the District of Columbia Department of Public Health began employing nonprofessional health education aides to supplement the work of professional public health educators in maternal and child health. The job qualifications for a health education aide were a high school diploma and 2 years of appropriate experience. By July 1967, six aides had been hired. While the public health educators dealt with program planning and other problems requiring professional skill, the health education aides sought out and met with pregnant women. The job description stated that the aide would participate in a program of public health education directed toward motivating pregnant women who had received little or no prenatal care to seek medical attention early in pregnancy. To prepare the aides for their assignments, intensive orientation and training for a 3-week period was carefully planned and carried out. The training consisted of informal classroom discussions, on-the-job observations, and field trips to health facilities. The greatest asset of the aides was their familiarity with the lifestyles of the women. The aides contacted the women, who might not have sought prenatal care on their own. The aides either sent or took approximately 40 hard-to-reach women to health department clinics each month of the program. The hard-to-reach women represented an increase of 400 patients during



1967, a total of 3,500 more patient visits than during 1966. During this period the patient load of the birth control clinics was increased by 37 percent, an actual increase of more than 4,600 women during 1967. 3 references.  
(HE9700061)

179

### **Using Lay Health Workers: Case Study of a Community-Based Prenatal Intervention.**

**Form:** Journal article.

**Authors:** Meister, J.S.; Warrick, L.H.; de Zapien, J.G.; Wood, A.H.

**Source:** Journal of Community Health. 17(1):37-51, February 1992.

**Abstract:** Researchers report on the design and implementation of a prenatal outreach and education intervention for low-income Hispanic and Hispanic American women living in three migrant and seasonal farmworker communities in southwest Arizona. Researchers designed the intervention to (1) identify pregnant women with inadequate or no prenatal care; (2) provide education support, advocacy, and referral; and (3) create an ongoing community resource of knowledge by training community women in aspects of conception, pregnancy, labor and delivery, postnatal care, and related topics. The intervention included three components: (1) a Spanish language prenatal education guide, (2) a delivery system using indigenous health educators, and (3) a support network of local health professionals. Researchers recruited a program coordinator/trainer who was a nurse midwife, was partly bilingual, and was familiar with Mexican culture. A fully bilingual and bicultural woman who had been a farmworker acted as a consultant. The program coordinator/trainer and the consultant informally recruited local women to act as health promoters and provided 2 months of training for 4 hours per week. Teaching the

health promoters to teach was as important as providing them with knowledge about pregnancy. During training, program staff recruited program participants by placing posters in stores, radio announcements, making visits to Women and Infant Children (WIC) groups, and talking with neighbors and friends. Each health promoter recruited 10 women for her class. Classes were held in three target communities. The program exceeded the planners' initial expectations, both in the extent and enthusiasm of response and in its ability to deliver an educational and social support program. Critical lessons learned include (1) how to maintain cultural relevance, (2) how to conduct a thorough initial community assessment to identify potential resistance, (3) how to ensure careful attention to the empowerment of community-based workers, and (4) how to collect data specifically to document the effect for funders and policymakers. 37 references. (HE9201187)

180

### **Working With Community Health Advisors as Part of the Community Health Team.**

**Form:** Journal article.

**Author:** Rudner, N.

**Source:** Journal of Public Health Management and Practice. 2(3):60-65, Summer 1996.

**Abstract:** Community health advisors (CHA's) typically come from sociocultural backgrounds similar to those of the target community and usually do not have formal education beyond high school. They may visit families, help them with family health needs, and provide support and encouragement. CHA's can bridge cultural gaps between health care providers and clients by using their communication skills, familiarity with the culture and experiences of clients, and training and information from the program. The

Resource Sisters/Companeras Program began in Florida in 1992 as a peer support program for pregnant women, with home visits by CHA's and peer support groups. The CHA's provide outreach and case management, and facilitate the peer support group. They work with caseloads of 60 pregnant women, helping them access health and social services, ensuring ongoing prenatal care, and providing peer support. Qualifications for CHA's include (1) experiences similar to those of clients, with some personal successes; (2) experience using public services, such as the local health department; (3) natural talent and warmth; (4) some successful work experience; (5) high school diploma or equivalent; and (6) own transportation. Of 13 CHA's hired, only 4 had the personal, social, and work skills to continue to be productive for more than 1 year. Some CHA's were uncomfortable with their role, which they saw as a negative link between their neighbors and the system; some felt anger and depression that interfered with their roles. Rugged individualism, which may have aided street survival, made it difficult for some CHA's to establish mutual trust or to build a team. Socioeconomic and educational differences between CHA's and clients often created distances that mitigated against the goal of developing staff who understood and related well with the community. Selecting supervisory staff for the CHA's proved harder than selecting CHA's. Successful supervisory staff had skills, maturity, and enthusiasm for working with the CHA's. Senior staff were nurses and social workers, average age 41 years, with an average of 17 years of work experience; all but one were black. Training was ongoing; new staff had an intensive month-long orientation, and staff also had weekly 2-hour training sessions covering case management, group facilitation, and staff-initiated issues. CHA's were urged to have a sense of ownership in their work and in the

program. A focus on the multiple strengths of the whole team and a shift from a hierarchical approach helped the CHA's. 14 references. (HE9700351)

## Sexual Behavior

181

### **Burnout, Social Support and AIDS Volunteers.**

**Form:** Journal article.

**Author:** Maslanka, H.

**Source:** AIDS Care. 8(2):195-206, 1996.

**Abstract:** A research consultant examined the effect that social support from agency staff and other volunteers had on the ability of volunteers working at the Gay Men's Health Crisis (GMHC) in New York City to deal with human immunodeficiency virus (HIV) volunteering, the rewards they experienced through volunteering, and their experience of burnout. Between 1988 and 1990, more than 874 individuals were enrolled in a 3-year longitudinal study of volunteers through weekly orientation meetings held at GMHC. Participants completed questionnaires addressing demographics and motivations for volunteering. A follow-up questionnaire mailed 6 months later to individuals who had been volunteering for at least 4 months contained measures of social support, rewards, and burnout, and was returned by 444 individuals, 265 of which were the study participants. Stress; social support; burnout (described through scales of exhaustion, depersonalization, lack of boundaries, and withdrawal); rewards (defined as new values, sense of efficacy, and sense of community); motivations; and length of volunteering were assessed. Results indicated that being younger and having experienced more stress lead to heightened perceptions of burnout while rewards and staff support help decrease that stress. By rewarding volunteers through being supportive of their achievements in their work, volunteers may well be protected from experiencing burnout. The only reward that did lessen burnout was that of a sense of

efficacy on the part of volunteers. The researcher concludes that although staff support may help ameliorate some burnout symptoms, a more realistic expectation of what their work entails would serve volunteers better. 4 figures, 2 tables, 18 references. (HE9700074)

182

### **Collaboration as a Strategy for Acquired Immunodeficiency Syndrome Prevention.**

**Form:** Journal article.

**Authors:** Kavanagh, K.H.; Harris, R.M.; Hetherington, S.E.; Scott, D.E.

**Source:** Archives of Psychiatric Nursing. 6(6):331-339, December 1992.

**Abstract:** Researchers report on a training project, the Peer Counseling Leadership Training Program (PCLT), developed to test the efficacy of an AIDS prevention model based on a strategy of collaboration between group participants called leader trainees and coinvestigator/leaders, to promote culturally acceptable behavioral alternatives aimed at reduction of risk for HIV infection. Nine black women, participants in a methadone maintenance program in Baltimore, Maryland, volunteered to attend and participate in a series of eight 2-hour sessions led by the four coinvestigators. A combination of quantitative and qualitative research methods allowed triangulation of data sources and analytical perspectives. Quantitative data were collected through use of instruments tested in an earlier study. The questionnaires investigated both personal and community activities. Qualitative data were collected through participant-observation in all sessions, discussions of group process, and field notes based on audiotaped postgroup sessions. The PCLT aimed at changing high-risk sexual and drug use



behaviors through collaborative counseling focused on incentives for positive change. Each session focused on discussion of a specific aspect of peer counseling and leadership training, AIDS, and modeling of effective communication and group facilitation skills. The results of the sexual and drug behavior questionnaires indicated that there was little evidence of safer sex practices on the pretest, but there were positive changes on the posttest, with the greatest change in the increased use of condoms. On the posttest, each woman who continued to use intravenous drugs reported either cleaning her tools appropriately with bleach and water or using new needles. Otherwise, drug use practices apparently did not change appreciably. Results of the PCLT indicate that this approach facilitates personal risk-reducing behavioral change, improved self-esteem, and community-based prevention efforts to promote behaviors that are assessed as beneficial and feasible. 70 references. (HE9700057)

183

### **Community AIDS/HIV Risk Reduction: The Effects of Endorsements by Popular People in Three Cities.**

**Form:** Journal article.

**Authors:** Kelly, J.A.; St. Lawrence, J.S.; Stevenson, L.Y.; Hauth, A.C.; Kalichman, S.C.; Diaz, Y.E.; Brasfield, T.L.; Koob, J.J.; Morgan, M.G.

**Source:** American Journal of Public Health. 82(11):1483-1489, November 1992.

**Abstract:** To replicate, extend, and better establish the generality of a model of intervention that trained popular opinion leaders in the gay community to serve as behavioral change endorsers to their friends and acquaintances, researchers evaluated the model sequentially in Biloxi, Mississippi, Hattiesburg,

Mississippi, and Monroe, Louisiana, during 1989 to 1991. The experimental design was a multiple baseline or sequential stepwise lagged design, in which (1) initial baseline survey data were collected in all three cities; (2) intervention was conducted in the first city; (3) surveys were repeated in all cities following the first city intervention; and (4) intervention was introduced in city two, and so on, until each city sequentially received the same intervention. To establish risk behavior levels among gay men, the researchers conducted anonymous surveys over three nights at the gay bars in each city. When they introduced the intervention into a community, they trained each bartender in that city's gay clubs to observe people in the club over a 1-week period and to identify individuals who were most popular with gay men. Researchers considered these people to be popular opinion leaders and recruited them for training. Opinion leaders attended four weekly 90-minute sessions in which the social skills they needed to serve as risk reduction endorsers to their peers were taught. Opinion leaders were taught how to (1) correct others' misconceptions concerning HIV/AIDS risk; (2) recommend to peers the strategies needed to implement risk reduction; and (3) personally endorse the benefits, importance, and social acceptability of making precautionary behavioral changes. Training used didactic and group discussion methods, modeling of effective health promotion messages, and extensive role playing. Each opinion leader contracted to have at least 14 conversations with peers; group sessions reviewed and reinforced these efforts. The results showed that the intervention consistently produced systematic reductions in the population's high-risk behavior of 15 percent to 29 percent from baseline levels, with the same pattern of effects sequentially repeated in all three cities. Researchers conclude that the results support the utility of norm-changing

approaches to reduce HIV risk behavior.  
4 figures, 1 table, 11 references. (HE9700053)

184

### **Effect of Peer Counselors on Adolescent Compliance in Use of Oral Contraceptives.**

**Form:** Journal article.

**Authors:** Jay, M.S.; DuRant, R.H.; Shoffitt, T.; Linder, C.W.; Litt, I.F.

**Source:** *Pediatrics*. 73(2):126-131, February 1984.

**Abstract:** Researchers tested the effect of a peer versus nurse counseling program on adolescent compliance with oral contraceptives. Participants were 57 adolescent females aged 14 to 19 years (55 blacks and 2 whites) residing in one of five federally funded housing projects in Augusta, Georgia, and registered in the Title V Children and Youth (C and Y) Project. Peer counselors were five adolescent females aged 17 and 18 years from the C and Y Project; three female nurses aged 26 to 29 years working in the C and Y Project served as the nurse counselors. The nurse counselor group included 31 participants; the peer counselor group included 26 participants. Each participant completed a pretest questionnaire measuring demographic variables, medical history, sexual activity and development, and sociopsychological variables (e.g., motivation for seeking birth control, factors for predicting compliance, autonomy, life crisis events, and adolescent life change). At the first visit, participants in both groups received one cycle of oral contraceptives and instruction on their use from either a peer or nurse counselor. Participants were followed up at 1, 2, and 4 months. At each follow-up appointment, participants received further counseling and oral contraceptives and provided a urine sample to be tested for the presence of a marker in the oral contraceptive capsule. Measures of

noncompliance included (1) whether the participant became pregnant during the previous month, (2) whether she missed her appointment, (3) whether she missed taking three or more oral contraceptives during the month, and (4) absence of urinary fluorescence at the time of follow-up. At the first and second month follow-ups, the participants in the peer-counseled group had significantly lower noncompliance than the nurse-counselor group. At the month 4 follow-up, a psychosocial indicator of hopelessness significantly interacted with the counseling groups' effect on compliance. The use of peer counselors may be beneficial in helping adolescents at high risk deal with their hopelessness by providing them with positive role models; in turn, this may increase their compliance with contraceptive regimens. 3 tables, 32 references. (HE9700095)

185

### **Nonprofit Sector's Response to the AIDS Epidemic: Community-Based Services in San Francisco.**

**Form:** Journal article.

**Author:** Arno, P.S.

**Source:** *American Journal of Public Health*. 76(11):1325-1330, November 1986.

**Abstract:** A health educator examines the role of nonprofit, community-based services in response to the AIDS epidemic in San Francisco, California. By the end of 1985, the reported number of AIDS cases in the city was 1,631. The city government contracted services of public health education, risk reduction strategies, psychosocial counseling, and home health care services to community-based organizations, including the San Francisco AIDS Foundation (SFAF), the Shanti Project, and Hospice of San Francisco. The SFAF, which works closely with the city health

department, university scientists, and market researchers, provided (1) public health education about AIDS through telephone services, educational events, media advertisements, media relations, and material development and distribution; (2) a privately funded food bank; and (3) a social services program that facilitated access to government programs including Social Security, General Assistance, and Food Stamp programs. The Shanti Project provided counseling services and a housing program. Hospice of San Francisco provided home health and hospice care to persons with AIDS. The SFAF and Shanti Project relied heavily on volunteers, whom they recruited and trained. Each volunteer committed a specific amount of time to an organization. At the AIDS Foundation, volunteers were seen as staff extenders; the paid professional staff was primarily responsible for the activities and volunteers assisted in carrying them out. At the Shanti Project, trained volunteers provided the bulk of the emotional support and practical support services themselves. Outpatient and inpatient services for persons with AIDS at San Francisco General Hospital were integrated with those provided by community-based groups. The author concludes that community-based organizations played a central role in responding to the AIDS epidemic. 6 tables, 23 references. (HE9700094)



## Injury and Violence

186

### **Approaches to Preventing Child Abuse: The Health Visitors Concept.**

**Form:** Journal article.

**Author:** Kempe, C.H.

**Source:** American Journal of Diseases of Children. 130(9):941-947, September 1976.

**Abstract:** The author recommends developing a national health visitors system as a strategy for preventing child abuse. It is routine for children to have periodic health assessments that include a standard history and physical examination. The author suggests supplementing these with standardized observations in the prenatal, perinatal, and postnatal care of families. The system would consist of lay health visitors (or nurses when available) who work with other health professionals to ensure that all of the children's basic health needs are met by facilitating and ensuring access to comprehensive health care for all children, especially during their first 4 years of life. The health visitors should be successful mothers who are able to share their experiences with less experienced young families and who will form a bridge between families and the health care system. These health visitors would get to know the families during pregnancy to establish a relationship and would visit regularly, not only in the first months of life but at least twice yearly in the second year of life and until the child reaches school age. Health visitors should go into the homes, weigh and measure the children, educate the family on health issues, and observe the family situation in order to determine what problems exist. Predicting and preventing child abuse is practical if standard observations are made early. By prioritizing early intervention, children receive some protection from

inappropriate parenting. The use of visiting nurses or indigenous health visitors is an inexpensive, nonthreatening, and efficient method of giving children the greatest possible chance to reach their potential. 4 tables. (HE9700491)

187

### **Injury-Prevention Program in an Urban African American Community.**

**Form:** Journal article.

**Authors:** Schwarz, D.F.; Grisso, J.A.; Miles, C.; Holmes, J.H.; Sutton, R.L.

**Source:** American Journal of Public Health. 83(5):675-680, May 1993.

**Abstract:** The Philadelphia Injury Prevention Program developed a model for a community-based injury-prevention project called the Safe Block Project. The project was a cooperative effort of the Philadelphia Department of Public Health, the University of Pennsylvania School of Medicine, the Children's Hospital of Philadelphia, and the Philadelphia Citizens Advisory Board for Injury Prevention. The project was designed to improve injury prevention knowledge and to reduce the number of hazards in the home and the rate of injury among residents of a poor, inner-city, predominantly African American community. The project combined several home injury-prevention strategies and applied them to situations in individual homes to lessen injury risks. Researchers assigned nine census tracts in the target community to either the intervention or the control area. The intervention, carried out by trained community outreach workers, consisted of (1) home modification for simple injury-prevention measures, (2) home inspection accompanied by information about home hazards, and (3) education about selected

injury-prevention practices. Approximately 12 months after the intervention, researchers assessed random samples of the control and intervention homes for home hazards and injury-prevention knowledge. Results indicated that a significantly larger proportion of intervention homes than control homes had adopted injury-prevention measures, such as functioning smoke detectors, syrup of ipecac, safely stored medications, and had reduced electrical and tripping hazards. There were no consistent differences on home hazards that required major effort to correct. 5 tables, 12 references. (HE9301036)

188

### **What's New in Elder Abuse Programming? Four Bright Ideas.**

**Form:** Journal article.

**Authors:** Wolf, R.S.; Pillemer, K.

**Source:** *Gerontologist*. 34(1):126-129, February 1994.

**Abstract:** Health educators present four models that address the common problems faced by community agencies dealing with elder abuse cases: a multidisciplinary case conference team (San Francisco, California); a victim support group (New York City); a volunteer advocacy program (Madison, Wisconsin); and a master's degree adult protective services track in social work (Hawaii). Information about these models was obtained through a detailed process of evaluation: (1) in-depth interviews with each of the project coordinators conducted twice during an 18-month period that addressed the history of the project and its aims, major activities, and distinctive features; (2) interviews with other project personnel; (3) interviews with staff members of the sponsoring agencies about the overall impression of the project; and (4) at least two site visits by the evaluation team to

each project to discuss daily operations. The San Francisco multidisciplinary team has nine members from various professions and settings, including case management, family counseling, civil law, geriatric medicine, and adult protective services. Community agencies refer cases to the team for various reasons, including clarifying the individual agency roles, receiving help in handling a nontypical case, and obtaining legal and medical consultation not readily available to them through other means. The Senior Advocacy Volunteer Program (SAVP) in Wisconsin interviews and trains volunteer advocates to pair with persons over age 59 years who had experienced or were in danger of experiencing abuse, neglect, or self-neglect. Requests came from public and private agencies that believed their clients would benefit from having more frequent visitation and more emotional support than their staff could provide. The Victim Support Group in New York was open to persons over age 59 years who were identified by agencies as victims of abuse and neglect inflicted by a family member. Participants reported that the group eased their sense of isolation, buffered their feelings of victimization, and served as a family for them. The master's level training in adult protective services in Hawaii provided students with an enriched placement program with a full-time field instructor who carefully monitored and supported the students as they gradually took responsibility for cases. The authors concluded that factors in the success of the four models included urban location, support of the local adult protective service system, and cooperation of agencies that form an elder abuse network. (HE9700099)



## Mental Health

189

### **Career Escalation Training: Five-Year Follow-Up.**

**Form:** Journal article.

**Authors:** Sainer, E.A.; Ruiz, P.; Wilder, J.F.

**Source:** American Journal of Public Health. 65(11):1208-1211, November 1975.

**Abstract:** In 1961, the Joint Commission of Mental Illness and Health recommended in its final report, Action for Mental Health, the launching of a national staff recruitment and training program for professionals and subprofessionals. It advocated that subprofessionals receive on-the-job training and that educational opportunities be made available for their career development. The development of the community mental health movement was largely in response to this mandate. As community mental health centers proliferated, the gap between the demand for mental health services and the existing staff supply became increasingly evident. An approach to a solution of this problem has been to develop a new group of health workers called paraprofessionals or indigenous workers. One mental health program that employs paraprofessionals, or indigenous workers, is the Lincoln Community Mental Health Center at Yeshiva University in the Bronx, New York. The indigenous worker was defined as a typical resident of an underprivileged area who was hired to work for social and economic improvement in the neighborhood. At the beginning of the 5-year program, the center employed 58 community mental health workers. The major objectives of the program were to have the workers acquire academic credentials, enhance their career mobility, and to retain new mental health worker careerists in the mental health field. Researchers followed

two groups of community mental health workers at the center over a 5-year period: the 18 workers who chose to enter a career escalation program, and the remaining 40 workers who did not enter the program for various reasons. Results showed that 12 of the 18 individuals in the career escalation program dropped out over the 5-year period for various reasons. The primary reason five of them left was the conflict between commitments to the program and family life. Others had increasing demands at work or dropped out of the program because of academic problems. In the second group, 17 of the 40 individuals who did not originally enter the program did so at later dates. Three achieved degrees, and 10 others were still pursuing degrees. Individuals who entered the career escalation program from both groups showed a high retention rate in the mental health field, whereas those who never entered the program did not. 5 references. (HE9700325)

190

### **Community-Oriented Program for Training and Using Volunteers.**

**Form:** Journal article.

**Authors:** Nicoletti, J.; Flater, L.

**Source:** Community Mental Health Journal. 11(1):58-63, Spring 1975.

**Abstract:** The authors developed and evaluated a community-oriented program for training and using volunteers with the goals of (1) providing a training program for individuals volunteering in the mental health profession, (2) providing an opportunity for the participants to apply their skills while assisting the center in meeting the needs of the community, (3) providing college credit for the volunteers as an incentive for participation, and (4) providing a



means for the community to learn about and participate in the functioning of a community mental health center. The participants consisted of 11 females from the Arvada (Colorado) community who had contacted the center for the purpose of offering their services as volunteers. The volunteers ranged in age from 24 to 40 years and had at least a high school degree. The community volunteer program consisted of two portions: training and practicum. Each session lasted 10 weeks, and the volunteers received three college credits per portion through a local university. The training portion provided the volunteers with cursory knowledge of the mental health field and various approaches used at the center. A large segment of the training addressed communication skills and discrimination (i.e., identification of the affect being expressed by the client, the area of interaction in which the statement occurred, and the effectiveness of the therapeutic response) via the use of videotapes and role playing. The practicum involved giving the volunteers the opportunity to participate in the various programs conducted at the center. Therapists supervised the volunteers during the practicum portion. The authors administered a communication written scale, a communication video role-playing segment, a written discrimination scale, and discrimination video segment to all participants before and after the training. The practicum was assessed by rating scales developed for therapy and consultation placements. The results of the evaluation support the effectiveness of training volunteers in communication and discrimination. Posttest scores for the volunteers showed significant change from pretest scores in the positive direction. Results imply that the use of volunteers can be extended from clerical tasks into the area of interpersonal helping. 4 tables, 4 references. (HE9700345)

191

### **Dilemma of Mental Health Paraprofessionals at Home.**

**Form:** Journal article.

**Authors:** Miller, B.G.; Pylypa, J.

**Source:** American Indian and Alaska Native Mental Health Research. 6(2):13-33, 1995.

**Abstract:** The authors present a preliminary model of the social placement of native caregivers and illustrate the implications of that placement for health care delivery. They apply an anthropological model of Coast Salish community dynamics to the Swinomish Tribal Mental Health Project, which employs native paraprofessionals on Coast Salish reservations. The use of Native American community members as lay health providers is complicated by the nature of the social relationships within the community and by the way changes in these relationships over time affect the provider's ability to be an effective helper. In Coast Salish communities, the core unit is the family network. However, family membership is flexible and individuals can belong to several different family networks by activating different kinship ties. For this reason, family network composition changes over time as new members are recruited, old members decide to disaffiliate themselves, new families form around one or more influential leaders, and old families lose their cohesion. Family networks appear to follow a fairly predictable cycle of growth, maturation, and collapse. The two ways these changes affect the individual's access to health care are: (1) the size of a network affects the availability of kin to provide such resources as care, transportation to facilities, and emotional support, and (2) the size and power of the network affects the individual's relationship to, and identification with, tribal institutions that provide services. At the Swinomish Tribal Mental Health Project,

the counselor's ability to be an effective helper is affected not only by the personal relationship between the counselor and client but also by the relationship between their respective family networks, the extent to which the counselor is regarded as the appropriate person to offer assistance, the client's willingness to share private family matters with the counselor, and the extent to which the family supports the counselor-client relationship. In addition, the client-counselor relationship is susceptible to change as interfamily alliances and rivalries develop and as family networks restructure over time by moving through the cyclical process of formation, growth, and collapse. The success of native paraprofessionals as health providers in Native American communities requires an understanding of these issues. 30 references. (HE9700786)

192

### **Lay Mental Health Counseling: Prospects and Problems.**

**Form:** Journal article.

**Author:** Carkhuff, R.R.

**Source:** Journal of Individual Psychology. 24(1):88-93, May 1968.

**Abstract:** The authors analyzed training programs that employ lay personnel. Findings indicated that after training, lay trainees function at levels as high or higher than do professional trainees on aspects of interpersonal functioning related to positive changes in clients. Interpersonal skills included empathy, respect, genuineness, concreteness, and self-disclosure. The evidence suggests that both the means and the intentions of prospective lay helpers are more humble and honest at the beginning of training than are the means and intentions of prospective professional helpers. Lay trainees function at lower levels of empathy, regard, and other facilitative

dimensions at the beginning of training than do professional trainees. Following the brief training programs of lay personnel and the extensive programs of professionals, the initial discrepancy is reversed in favor of the lay person. Professional training programs are very cognitively oriented toward developing diagnostic understanding and research skills. The lay training programs focus on sensitivity training, interpersonal skills, and changing personal attitude by emphasizing patient involvement and action. Professional programs, on the other hand, focus on affecting changes unrelated to counselee or trainee change. Data suggest that trainers of professional persons function below a minimally facilitating level of interpersonal functioning, at levels equal to or lower than professional trainees at the beginning of graduate training. Lay persons, with or without training and/or supervision, have patients who demonstrate change as great or greater than do the patients of professional practitioners. The professional helper all too often focuses upon highly elaborate, highly cognitive treatment systems. The potential causes of these findings vary greatly. The author concludes that whatever allows one individual to help another is not the sole and exclusive province of professional helpers. Increased use of lay personnel in inpatient and outpatient treatment should take place. The authors suggest an elevation of the professional's role to one involving practice, training, supervision, consultation on preferred modes of treatment, and research. The demonstrated efficacy of lay programs has implications for professional training. 18 references. (HE9700339)



193

### **Linking Low-Income Families to Children's Mental Health Services: An Outcome Study.**

**Form:** Journal article.

**Authors:** Koroloff, N.M.; Elliott, D.J.; Koren, P.E.; Friesen, B.J.

**Source:** Journal of Emotional and Behavioral Disorders. 4(1):2-11, January 1996.

**Abstract:** Researchers evaluated an intervention designed to address barriers that interfere with access to children's mental health services for low-income families. The approach involved the use of paraprofessionals called family associates who served as advocates by providing families with information, emotional support, and help with such barriers as lack of transportation and lack of child care for other children. The intervention was implemented in three Oregon counties; four other counties served as the control condition. The target population consisted of families with a child aged 4 to 18 years who was referred for mental health services through early and periodic screening, diagnosis, and treatment. Families were included if the referred child was not in an institutional placement, the caregiver was involved in managing the child's mental health services, and the child had attended no more than three mental health service appointments associated with the referral. The final sample consisted of 239 families, 96 of whom received the family associate intervention and 143 of whom served as comparison families. The intervention and comparison groups had similar demographic profiles. Upon referral, participants completed an initial research interview. Approximately 3 to 4 months later, they were interviewed again to collect information about mental health services received, satisfaction with those services, barriers to child mental health services, the

extent to which the Family Associate helped to overcome the barriers, and changes in the family's sense of empowerment. Results showed that the intervention group was more likely than the comparison group to initiate child mental health services; however, the groups did not differ in their rates of attendance or premature discontinuation of service. The intervention families showed a modest but significant increase in empowerment at posttest. The researchers concluded that the family associate intervention can help families initiate child mental health services and increase their sense of empowerment. They recommended that future research explore the importance of barriers related to limited income and the stresses of daily living. 4 tables, 53 references. (HE9700785)

194

### **New Trends in Volunteer Services for the Mentally Handicapped.**

**Form:** Journal article.

**Author:** Naylor, H.

**Source:** Hospital and Community Psychiatry. 22(4):109-111, April 1971.

**Abstract:** Many lay consumers of mental health services and their volunteer advocates now participate in policy development and program planning. A study released by the National Institute of Mental Health in November of 1969, Nonprofessional Personnel in Mental Health Programs, documented the ways in which volunteers as well as paraprofessionals can supplement staffing of mental health programs. Some of these volunteer functions include (1) caretaking, such as feeding or escorting patients, (2) social sustenance in the form of relationships with mentally ill or developmentally delayed individuals, (3) professional assistance, and (4) bridging the gap between patients and



community services. In addition to these functions, advocacy is a major role of the mental health volunteer. Concerned citizens can make significant contributions as supporters and defenders of the mentally ill and developmentally delayed. As a participating citizen and potential consumer, the volunteer advocate can speak more freely than paid staff and can try to influence important decision making. Volunteers, however, are not always readily accepted by professional staff. Mental health professionals should recognize the importance of volunteers, understand where they can be used, and be prepared to use them in an effective manner. (HE9700330)

195

**Rural Mental Health Delivery System:  
Four Corners Community Mental Health  
Center, Price, Utah.**

**Form:** Journal article.

**Author:** Anon.

**Source:** Hospital and Community Psychiatry. 26(10):671-674, October 1975.

**Abstract:** Community leaders and health professionals established the Four Corners Community Mental Health Center in southeastern Utah in 1972 to begin to try to bring comprehensive community mental health services to a vast, sparsely populated multiethnic region whose residents had no previous experience with mental health programs. Culturally diverse communities included Native Americans (Navajos, Utes, and Piutes), Chicanos, and descendants of Greek and other southern Europeans. Because the staff faced such obstacles as long distances between patients' homes, cultural barriers, and a mistrust of mental health programs, they decided to establish a diverse system of mental health care delivery that consisted of two central offices with nine satellite clinics. The

staff also recruited 250 volunteers from the local communities to help handle the average monthly load of 600 outpatient visits, 100 day-care patient visits, and 20 emergency visits. Cultural differences were a major problem for the program because many Navajos did not trust outsiders, hospitals, or mental health services. Therefore, staff members met with local tribal chairmen about the program and trained Navajo women to serve as outreach workers in the community. In dealing with the Chicano population, staff also encountered a mistrust of mental health centers, so the program staff provided services through a Chicano cottage, which offered community services and activities, as well as mental health services. In this way, the mental health services were more integrated into other community activities. Essentially, the staff's successful approach to the center was to enter each community with outreach workers and indigenous volunteers, find out what the people want, and then help them get it. (HE9700329)

196

**Training of Paraprofessionals as Behavior  
Modifiers: A Review.**

**Form:** Journal article.

**Authors:** Balch, P.; Solomon, R.

**Source:** American Journal of Community Psychology. 4(2):167-179, June 1976.

**Abstract:** The authors reviewed the use and training of paraprofessionals serving as behavior modifiers in the mental health field. The paraprofessional populations included (1) psychiatric aides and nurses, (2) college students, (3) inpatients, and (4) community and indigenous workers. The studies illustrated the frequent use of psychiatric aides and nurses as paraprofessional behavior modifiers. Early training efforts primarily involved instructions on what to do with specific patients; later

reports indicated readings, lectures, and discussions as didactic instructional tools. The studies indicated that training of college students as behavior modifiers appeared strongly tied to didactic presentations, and was often offered in conjunction with college credit. The generalizability and utility of these programs was limited because of the selection criteria employed, use of a team approach, and the considerable input of professional and staff time. An important area for the use of paraprofessionals as behavior modifiers was the training of community and indigenous volunteers to function in the natural environment. Studies in which volunteers were trained included (1) a group of volunteers trained by Tharpe and Wetzel (1969) as consultants to mediators in order to conduct behavior assessments, collect and organize data, and implement intervention strategies for behaviorally disordered children; (2) community volunteers (public health nurses, public assistance workers, and private citizens) trained by Wahler and Erickson (1969) to function as behavior therapists in home and school settings; (3) five groups of ethnically diverse volunteers working in child care centers trained by Wetzel (1970) to implement behavioral intervention strategies for children; and (4) a speech therapist trained by Laws, Brown, Epstein, and Hocking (1971) to modify the inappropriate social behaviors of three boys enrolled in a day care remedial language program. The studies suggested that behaviorally trained paraprofessionals had the potential to work effectively with clients who were often excluded from mental health services. Training techniques tended to minimize more academic procedures in favor of inservice and on-the-job training formats. The authors concluded that a strong case could be made for the administrative feasibility of training and using diverse groups of paraprofessionals as behavior modifiers. The

lack of consistent, solid outcome evidence prohibited a conclusion as to the effectiveness of these paraprofessionals. 36 references. (HE9700332)

197

### **Use of Bilingual, Bicultural Paraprofessionals in Mental Health Services: Issues for Hiring, Training, and Supervision.**

**Form:** Journal article.

**Authors:** Musser-Granski, J.; Carrillo, D.F.

**Source:** Community Mental Health Journal. 33(1):51-60, February 1997.

**Abstract:** To help refugees and immigrants bridge language and cultural barriers and educate communities about mental health services, agencies are recruiting bilingual and bicultural paraprofessionals to provide interpreting services and perform outreach functions. The paraprofessional's role in community outreach involves educating and disseminating information about mental health, advocacy, community organization, prevention, and initial assessment and referral. If members of a particular culture are not familiar with mental health services and concepts, outreach workers can educate them and help them overcome attitudinal barriers. In addition, the workers can network with other agencies and individuals and provide these referral sources with a directory of mental health providers who work with populations who speak limited English. Another role for bilingual, bicultural workers is interpreting in clinical settings. These workers can provide critical information about whether clients' words, attitudes, and behaviors are considered normal and acceptable in their culture and can advise the therapist about questions that might be perceived as offensive or threatening. The authors recommend that, when hiring a bilingual,



bicultural paraprofessional, the agency should consider cultural role expectations and the worker's fluency in both native and English languages, knowledge of the native culture, and such personal qualities as empathy, confidence, and respect for the client and the client's confidentiality. Other recommendations include pay scales and career development for paraprofessionals. Adequate training is critical so that the worker provides accurate, unbiased, and complete translations while interpreting during therapy. In addition, the interpreter should be knowledgeable about mental health terminology and concepts, basic counseling and interviewing skills, and relevant ethical and legal issues. The therapist may need to help the worker with such issues as transference, personal boundaries, and conflict between the cultural demands of the community and the requirements of the agency. The mental health professional and bilingual staff can work together to meet the needs of the local community and provide effective culturally appropriate services. 27 references. (HE9700784)

198  
**Use of Paraprofessionals in Crisis Intervention: Evaluation of an Innovative Program.**

**Form:** Journal article.

**Authors:** Getz, W.L.; Fujita, B.N.; Allen, D.

**Source:** American Journal of Community Psychology. 3(2):135-144, June 1975.

**Abstract:** The authors examined the effect of a single-session mental health crisis intervention service staffed by volunteer paraprofessionals and situated in the emergency room of a community hospital. They also proposed and implemented a model of program evaluation that used service deliverers, e.g., crisis counselors, as researchers. The University of

Washington supplied the majority of the program staff. The hospital is located in a metropolitan area of the northwest and serves a primarily middle-class, suburban cachement area. Staffing for the program consisted of well-trained graduate students and community volunteers. The 293 consecutive individuals in crisis who contacted the service from May 1971 to March 1972 provided the initial sample. The crisis counselor/researchers gathered data from client intake reports completed by the crisis counselor and from medical records. They followed up by telephone 6 to 12 months after the last client services contact. Follow up was completed for 39 percent of the sample. If possible, the researcher who compiled the data from the intake was responsible for the follow up. During follow up, researchers asked the clients to evaluate (1) the effectiveness of the service, (2) the crisis counselor's use of referrals, (3) the major source of change in the crisis situation, and (4) the improvement for their problem. Findings indicate that the effect of the program in all four evaluation areas was significant. There was no significant difference in client assessment of the helpfulness of students and volunteers. The data support the notion that timely intervention by paraprofessionals in crisis situations may have lasting effects on particular kinds of problems. The clients most significantly affected were those with depression, anxiety, family discord, and suicidal problems. The use of crisis counselors as researchers provided feedback to the counselor directly from the consumer about the kinds and quality of service received. 5 tables, 7 references. (HE9700333)



199

**Volunteers as Relationship Therapists for Institutionalized Geriatric Patients.**

patients and in challenging the stereotype that only professionals can effectively counsel.

7 references. (HE9700323)

**Form:** Journal article.

**Authors:** Eichler, M.; McCuan, L.R.; Berdit, L.

**Source:** Mental Health and Society. 3(3-4):212-222, 1976.

**Abstract:** The authors conducted a 3-year demonstration project to train nonprofessional volunteers to carry out relationship therapy with emotionally disturbed geriatric patients at a Baltimore, Maryland long-term care, elderly home and chronic disease hospital. Recruitment for the program included announcements in the volunteer organization, news articles in local papers, and brief radio and television spots. Researchers used the mass media to recruit the widest range of possible volunteers. A psychiatric social worker conducted interviews with all the applicants and assessed their potential to effectively provide counseling. All applicants also completed a written essay on life experiences. Volunteer training consisted of weekly meetings of 1 hour with the program's psychiatrist-director, as well as 1 hour per week of supervision by a social worker. Midway through the training, the volunteers received patients with whom they worked on a one-to-one basis. During the 3 years of the program, 25 volunteers were approved for participation and 17 actually completed the training and began working directly with patients. Because programs such as the volunteer counselor service succeed only if the volunteer is both challenged and supported, researchers were careful to provide adequate supervision and additional training to volunteers and to carefully assess potential counselor-patient personality combinations. The authors conclude that, overall, the volunteer program was successful in helping

## Substance Abuse

200

### **Effects of a Peer-Counseled AIDS Education Program on Knowledge, Attitudes, and Satisfaction of Adolescents.**

**Form:** Journal article.

**Authors:** Rickert, V.I.; Jay, M.S.; Gottlieb, A.

**Source:** Journal of Adolescent Health.

12(1):38-43, January 1991.

**Abstract:** A study examined the effects of a peer-led versus adult-led AIDS education program on the attitudes, knowledge, and satisfaction of adolescents with the education program. The study recruited the sample of 82 adolescents (55 female and 27 male, mean age 15.8 years) from participants in community and church organizations. The study determined participants' socioeconomic status by using the Hollingshead Four Factor Index of Social Status; results suggested that participants were from low- to upper- middle class families. The study selected nine adolescent peer counselors, based on their willingness to participate; peer counselors attended a 4-hour training session on 2 consecutive days. The peer counselors were six females and three males between the ages of 14 and 18 from similar community organizations. All peer counselors and participants were white, to eliminate the effect of race. Health care providers experienced with AIDS acted as adult counselors. Researchers randomly assigned adolescents to groups that were either led by peers, led by adults, or control. The adult-led group heard a lecture about AIDS and viewed a videotape about transmission and prevention. The peer-led group received the same presentation. Subjects in all three groups completed the AIDS Knowledge Questionnaire-Revised, the AIDS Attitude Survey, and a measure of consumer satisfaction. Analyses of the surveys revealed

that the peer-led and adult-led interventions had a statistically significant effect on increasing knowledge about AIDS and heightening attitudes toward practicing personal preventive behaviors. Both the peer-led and adult-led groups had results superior to the controls. Adolescents counseled by peers engaged in more interactive discussion following the educational intervention than those counseled by adults. 28 references. (SA9100249)

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### **Paraprofessional and Professional Teamwork and Training in Managing PCP and Other Drug Abuse Problems.**

**Form:** Journal article.

**Authors:** Chappel, J.N.; Smith, D.E.; Buxton, M.

**Source:** Journal of Psychedelic Drugs. 12(3-4):301-306, July-December 1980.

**Abstract:** The authors address the need for professional and paraprofessional teamwork and training in managing PCP and other drug abuse problems. They emphasize the need for continuing education and the difficulties in obtaining it, including (1) the excessive formality, (2) limited or static models, and (3) negative attitudes. The authors also discuss the role of paraprofessionals in this area. Professionals and paraprofessionals must view each other as allies and share their skills in attempting to solve the complex problems of PCP and other drug abuse. Methods used by paraprofessionals have not always been those taught by professional schools, but they have proved very effective. The authors emphasize the need for additional paraprofessional training to provide clinical skills to supplement their street-survival skills that have worked so well in alcohol and drug abuse programs. Ex-addict

counselors have been told that the treatment of PCP abuse should be left in the hands of formally educated professionals. However, a 1979 National Institute on Drug Abuse report compared professionals, counselors who had no drug abuse problems, and ex-addict counselors in their job performance. No significant difference was found in the clients' retention in treatment, criminality, or employment. Counselors' attitudes toward clients were very similar and program administrators viewed all the counselors as competent, saw little difference between the groups, and assigned clients without evidence of bias. The authors point out that many of the recommended therapies for drug addicts can be carried out as well by paraprofessionals as they can be by professionals. Training activities should be based on the principles of adult education. The authors outline the steps for organizing an effective inservice training program. The authors state that the most effective clinical problem solving occurs when health professionals and paraprofessionals work together with flexibility and mutual respect. 22 references. (HE9700060)

202

### **Paraprofessional and Professional Teamwork and Training in the Treatment of Drug Dependence.**

**Form:** Journal article.

**Author:** Chappel, J.N.

**Source:** Journal of Psychedelic Drugs. 12(2):123-129, April-June 1980.

**Abstract:** A psychiatrist describes the experience of paraprofessional and professional teamwork and training in the Illinois Drug Abuse Program (IDAP). IDAP was a former multimodality, community-based program with more than 40 treatment units providing methadone and abstinence services in

residential and outpatient settings for more than 4,500 persons. Problems in achieving teamwork between paraprofessionals and professionals included (1) words and titles denoting recognition and positive and negative status, (2) power struggles between professionals and paraprofessional staff, (3) the need for credit, (4) differences in the way professionals and paraprofessionals approach those they are trying to help, and (5) behavior patterns of professionals and paraprofessionals that may interfere with teamwork. The problems arose from a variety of sources, the most important of which include (1) feelings of insecurity, (2) feelings of inadequacy, (3) myths and stereotypes, and (4) work stress. Solutions that have been useful in developing and preserving treatment teams include (1) staff groups, (2) inservice training, (3) education, (4) supervision, (5) treatment, and (6) evaluation. Overcoming the obstacles impeding effective teamwork and developing better treatment services requires ongoing effort and evaluation. 2 tables, 20 references. (HE9700059)



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**Community Health Advisors/Workers: Volume III**  
**Selected Annotations and Programs**  
**June 1998**

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# Community Health Advisors: Programs in the United States

## Health Promotion and Disease Prevention

### Program Descriptions

#### Cancer

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**Program** • Best Chance Network.

**Contact** • Nickerson, Brenda.

**Agency** • South Carolina Department of Health and Environmental Control, Division of Cancer Prevention and Control, Box 101106, Columbia, SC 29211. (803) 737-3934.

**Program Dates** • 1991–continuing.

**Delivery Sites** • Private physicians' offices, primary health care centers, hospital outpatient clinics, mammography facilities.

**Funding Source(s)** • Centers for Disease Control and Prevention.

**Primary Purpose** • To reduce breast and cervical cancer by providing comprehensive prevention and control services to women in South Carolina.

**Services Offered** • Outreach workers contact women (one on one and in small groups) to educate them about breast and cervical cancer; they also provide follow-up to women diagnosed with abnormalities.

**Materials Used** • Educational instruction and materials for the community, patients, and professionals.

**Health Topic(s) Addressed** • Breast and cervical cancer.

**Geographic Area/Unit** • State.

**Target Population** • Uninsured and underinsured women who are income-eligible (up to 250 percent of the poverty level), particularly minority women and women aged 50 years and older.

**CHA Title** • Outreach workers.

**CHID Accession Number** • CP94P0449.

204

**Program** • **Breast and Cervical Cancer Education.**

**Contact** • Carcar, Noemi.

**Agency** • Mercy Mobile Health Care, 60 11th Street, Atlanta, GA 30309.  
(404) 249-8104.

**Program Dates** • March 1995–continuing.

**Delivery Sites** • Homes, community sites, hospital/medical clinic.

**Funding Source(s)** • Fannie Mae Foundation, Avon Foundation.

**Primary Purpose** • To educate low-income Hispanic and Asian American women about early detection of breast and cervical cancer to make referrals for clinical examinations.

**Services Offered** • Patient outreach and education, cancer detection tests.

**Materials Used** • Shower cards, handouts/brochures, breast model, cervix model.

**Health Topic(s) Addressed** • Breast and cervical cancer.

**Geographic Area/Unit** • Multicounty.

**Program Setting** • Community-based agency, religious institution, hospital.

**Target Population** • Low-income Hispanic and Asian American women living in a five-county area in Georgia.

**CHA Title** • Outreach worker, resource specialist.

**CHA Roles** • Outreach, health promotion/education, follow-up.

**CHA Training** • 40 hours of initial training and 1 hour per month of inservice training.

**CHA Compensation** • \$8.50 per hour plus health insurance, tuition reimbursement, and mileage reimbursement.

**Number of CHA's** • 3.

**Number of Clients  
Served in 12 Months** • 1,053.

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*Evaluation Plan* • Yes.

*Methods Used to Recruit CHA's* • Networking with community-based organizations, internal posting of job opportunities, word of mouth.

*Methods Used to Retain CHA's* • Educational opportunities, health benefits.

*Methods Used to Recruit Clients* • Outreach/education, clinical services.

*Methods Used to Retain Clients* • Case management follow up, employee dedication and persistence.

*CHID Accession Number* • CP96P0481.



205

**Program** • Chicago Ethnic Communities Breast Cancer Education and Screening Outreach.

**Contact** • Rodin, Miriam B.

**Agency** • Northwestern University, McGaw Medical Center, Buehler Center on Aging, Suite 601, 750 North Lake Shore Drive, Chicago, IL 60611-2611. (312) 503-2560.

**Program Dates** • July 1996–continuing.

**Delivery Sites** • Community.

**Funding Source(s)** • U.S. Army Materiel Command, Illinois Department of Public Health.

**Primary Purpose** • To increase awareness of and adherence to breast cancer screening guidelines among immigrant, refugee, and selected underserved ethnic women.

**Services Offered** • Native-language training in women's health, breast cancer facts, breast and cervical cancer screening guidelines, on breast self-examination, techniques for health behavior change.

**Materials Used** • Flash cards on breast cancer and how to perform breast self-examination.

**Health Topic(s) Addressed** • Breast and cervical cancer, women's health, health behavior change.

**Geographic Area/Unit** • City.

**Program Setting** • Medical school.

**Target Population** • Low-income uninsured and underinsured women aged 25 years and older.

**CHA Title** • Peer educator.

**CHA Roles** • Transmit knowledge, skills, and attitudes; facilitate screening among local networks of women.

**Number of CHA's** • 50.

*Evaluation Plan* • Rigorous evaluation of learning objectives and proficiency in breast self-examination (BSE), including pretest and posttest measures of knowledge and BSE proficiency.

*CHID Accession Number* • CP97P0209.

206

**Program** • Community Charge on Cancer.

**Contact** • Boone, Dorothy.

**Agency** • New Hanover Regional Medical Center, 8975 Highway 117 South, Rocky Point, NC 28457. (910) 675-3279.

**Program Dates** • May 1995–continuing.

**Delivery Sites** • Schools, worksites, religious organizations, homes, community centers.

**Funding Source(s)** • Private foundation.

**Primary Purpose** • To provide breast and cervical cancer education and prevention for black women aged 20 years and older.

**Services Offered** • Cancer education and health promotion, counseling, transportation.

**Materials Used** • Training guide, teaching aid.

**Health Topic(s) Addressed** • Breast and cervical cancer.

**Geographic Area/Unit** • Rural, county.

**Program Setting** • State health department, local health department, hospital/medical clinic/health maintenance organization, university/medical school.

**Target Population** • Black women aged 20 years and older.

**CHA Title** • Community health advisor.

**CHA Roles** • Health promotion/education, social support/counseling, transportation, community organizing.

**CHA Training** • 9–24 hours of initial training and 2–4 hours per month of inservice training.

**CHA Compensation** • None.

**Number of CHA's** • 27.



*Evaluation Plan* • Yes.

*Methods Used to Recruit CHA's* • Referrals from other CHAs, word-of-mouth referral.

*Methods Used to Retain CHA's* • Graduation ceremony, program certificate.

*CHID Accession Number* • CP97P0334.

207

**Program** • Do It for Life/Hazlo por la Vida: Worksite Breast Cancer Education Project.

**Contact** • Marquardt, Joan.

**Agency** • Colorado Department of Public Health and Environment, Prevention Program Division, PPD-CCP- A5, 4300 Cherry Creek Drive, South, Denver, CO 80222-1530. (303) 692-2557.

**Program Dates** • September 1994–December 1997.

**Delivery Sites** • Worksites.

**Funding Source(s)** • Federal agency.

**Primary Purpose** • To educate minority women about prevention and early detection of breast cancer.

**Services Offered** • Educational presentations on breast cancer, self-detection of the disease, and its early detection by mammography.

**Methods Employed** • Instruction and demonstrations using breast models.

**Materials Used** • Do It for Life art boards, women's health calendar, CHA training manual.

**Health Topic(s) Addressed** • Breast cancer.

**Geographic Area/Unit** • Urban, multicounty.

**Program Setting** • State health department.

**Target Population** • Asian American, Hispanic American, and black women aged 20 years and older.

**CHA Title** • Peer educator.

**CHA Roles** • Health promotion/education.

**CHA Training** • 8 hours or less of initial training and less than 2 hours per month of inservice training.

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*CHA Compensation* • Occasional cash incentives.

*Number of CHA's* • 17.

*Evaluation Plan* • Yes.

*Methods Used to Recruit CHA's* • Advertising, referrals from other CHA's, word-of-mouth referral.

*Methods Used to Retain CHA's* • Program certificate, cash incentives.

*Methods Used to Recruit Clients* • Personal memos/fliers, word of mouth, posters, e-mail, company newsletters.

*CHID Accession Number* • CP97P0331.



208

**Program** • **Encore Plus.**

**Contact** • Ducker, Valerie.

**Agency** • YWCA of the National Capital Area, 624 Ninth Street, NW,  
Washington, DC 20001. (202) 626-0700.

**Program Dates** • July 1994–June 1995.

**Funding Source(s)** • Avon Breast Cancer Crusade grant provided through the YMCA of America.

**Primary Purpose** • To provide breast and cervical cancer education and screening to uninsured women in the District of Columbia.

**Services Offered** • Referrals to screening, transportation, child care, follow-up support.

**Methods Employed** • Works with community agencies to assist in recruiting participants and identifying community outreach workers in specific locations.

**Materials Used** • Encore Plus manual, education curriculum, flyer.

**Health Topic(s) Addressed** • Breast and cervical cancer.

**Geographic Area/Unit** • City.

**Target Population** • Uninsured women in the District of Columbia.

**CHA Title** • Community outreach workers.

**Evaluation Plan** • Program uses a system developed by the YMCA USA's Office of Women's Health Initiatives.

**CHID Accession Number** • CP95P0269.

209

**Program** • **Juntos Contra el Cancer: Together Against Cancer.**

**Contact** • Meister, Joel S.

**Agency** • Mariposa Community Health Center, c/o Joel S. Meister, 2613 East Elm Street, Tucson, AZ 85716. (520) 327-5925.

**Program Dates** • Continuing.

**Delivery Sites** • Homes, community centers, health maintenance organizations.

**Funding Source(s)** • Federal agency.

**Primary Purpose** • To transfer cancer education and prevention information and skills from health professionals to community-based lay health promoters in Hispanic communities.

**Services Offered** • Training of lay health promoters, outreach to neighborhood residents, presentations at schools and other community organizations.

**Methods Employed** • Small group meetings, distribution of educational materials at local social service and community service organizations, presentations at schools and to youth organizations, and cancer self-examination modeling.

**Materials Used** • Curriculum and training guide in English and Spanish.

**Health Topic(s) Addressed** • Cancer.

**Geographic Area/Unit** • County.

**Program Setting** • Community-based agency.

**Target Population** • White and Mexican American adolescents and adults.

**CHA Title** • Promotora (lay health promoter).

**CHA Roles** • Health promotion/education, risk identification, social support/counseling, transportation, community organizing.

**CHA Training** • 25–40 hours of initial training and more than 4 hours per month of inservice training.

## Cancer

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**CHA Compensation** • \$7.25 per hour plus health insurance, sick/vacation days, pension plan, and retirement plan.

**Number of CHA's** • 3.

**Evaluation Plan** • Written and oral pretests and post-tests to determine the effectiveness of the training in transferring information and skills to lay health promoters; community surveys on cancer knowledge, attitudes, beliefs, and behavior to determine lay health promoters' effectiveness in educating community members.

**Methods Used to Recruit CHA's** • Advertising; word-of-mouth referral; networking with other community health advisor programs; referrals from other lay health promoters, community groups, and professionals.

**Methods Used to Retain CHA's** • Graduation ceremony, program certificate, pay increase.

**Methods Used to Recruit Clients** • Door-to-door contact, community presentations, informal neighborhood get-togethers, school contacts.

**CHID Accession Number** • CP97P0332.



210

**Program** • New Mexico Breast and Cervical Cancer Detection and Control Program.

**Contact** • Salas, Anita.

**Agency** • New Mexico Department of Health, 2329 Wisconsin Street, NE, Suite A, Albuquerque, NM 87110. (505) 841-8330.

**Program Dates** • July 1991–continuing.

**Delivery Sites** • Indian Health Service primary care clinics, public health offices, Planned Parenthood clinics, private physicians' offices.

**Funding Source(s)** • Centers for Disease Control and Prevention.

**Primary Purpose** • To provide comprehensive breast and cervical cancer screening to low-income, medically underinsured women in New Mexico.

**Services Offered** • Promotoras recruit women in the community into the program for screening; they follow up with women who have abnormal test results; they provide public education.

**Methods Employed** • Direct provision of screening services, outreach.

**Materials Used** • Descriptive brochure in Spanish and English.

**Health Topic(s) Addressed** • Breast and cervical cancer.

**Geographic Area/Unit** • State.

**Program Setting** • State department of health.

**Target Population** • Low-income, medically underinsured women in New Mexico.

**CHA Title** • Promotoras.

**Methods Used to Recruit Clients** • Outreach through program staff, CHA's, and the media.

**CHID Accession Number** • CP96P0279.

211

**Program** • **Save Our Sisters--Wake County.**

**Contact** • Burnette, Delores.

**Agency** • Wake County Health Department, 10 Sunnybrook Road, Raleigh, NC 27610. (919) 250-1078.

**Program Dates** • Continuing.

**Delivery Sites** • Schools, worksites, religious organizations, homes, community centers.

**Funding Source(s)** • Private foundation.

**Primary Purpose** • To provide breast cancer education and prevention for black women.

**Services Offered** • Health promotion/education, counseling, transportation.

**Materials Used** • Training guide, teaching aid.

**Health Topic(s) Addressed** • Breast cancer.

**Geographic Area/Unit** • Urban, county.

**Program Setting** • State health department, local health department, hospital/medical clinic/health maintenance organization.

**Target Population** • Black women aged 20 years and older.

**CHA Title** • Community health advisor.

**CHA Roles** • Health promotion/education, social support/counseling, transportation.

**CHA Training** • 9–24 hours of initial training and less than 2 hours per month of inservice training.

**CHA Compensation** • None.

**Number of CHA's** • 30.

**Evaluation Plan** • Yes.

*Methods Used to Recruit CHA's* • Referrals from other CHA's, word-of-mouth referral, referrals from community groups and professionals.

*Methods Used to Retain CHA's* • Graduation ceremony, program certificate.

*CHID Accession Number* • CP97P0333.



212

**Program** • Utah Cancer Control Program.

**Contact** • Rowley, Kathryn.

**Agency** • Utah Department of Health, Bureau of Chronic Disease Control, 288 North 1460 West, P.O. Box 16660, Salt Lake City, UT 84116-0660. (801) 538-6712.

**Program Dates** • October 1994–continuing.

**Delivery Sites** • Religious organizations, community sites, migrant centers/camps, public health clinics, hospitals/medical clinics.

**Funding Source(s)** • Centers for Disease Control and Prevention, state legislature.

**Primary Purpose** • To reduce breast and cervical cancer morbidity and mortality among women in Utah.

**Services Offered** • Free and low-cost screening, including clinical breast examinations, pelvic examinations, Pap tests, blood pressure readings, and mammography, and diagnostic follow-up.

**Methods Employed** • Media campaigns, networking, community presentations.

**Materials Used** • Training guide; teaching aid; promotional materials such as buttons, magnets, and breast self-examination stickers.

**Health Topic(s) Addressed** • Breast and cervical cancer, high blood pressure.

**Geographic Area/Unit** • State.

**Program Setting** • State health department.

**Target Population** • Qualifying women aged 20–64 years.

**CHA Title** • CCP (Cancer Control Program) volunteer.

**CHA Roles** • Outreach, health promotion/education, patient/community advocacy, patient treatment/services, social support/counseling, transportation.

**CHA Training** • 1–6 hours of initial training.

**CHA Compensation** • None.

*Number of CHA's* • 30 trained speakers.

*Number of Clients Served in 12 Months* • 5,500.

*Methods Used to Recruit CHA's* • Phone calls to participants in breast cancer task force advisory groups, referrals from peer workers, word of mouth.

*Methods Used to Retain CHA's* • Written and oral encouragement, including expressions of appreciation and information on the number of women helped and diagnosed.

*Methods Used to Recruit Clients* • Annual media campaign, reminder letters to women who have been screened, networking with other community groups.

*Methods Used to Retain Clients* • Maintaining good rapport between clients and clinicians, tracking and follow-up, using women from the target population to assist in screening clients.

*CHID Accession Number* • CP96P0166.





## Cardiovascular Disease

213

**Program** • Center for Health Promotion.

**Contact** • Stalker, Varena.

**Agency** • University of Alabama at Birmingham, 201 Mortimer-Jordan Hall, Birmingham, AL 35294. (205) 975-8383.

**Program Dates** • 1992-continuing.

**Delivery Sites** • Homes, community centers.

**Funding Source(s)** • Centers for Disease Control and Prevention.

**Primary Purpose** • To reduce cardiovascular disease risk among rural African American women over 39 years of age.

**Services Offered** • Health education classes, self-help activities, referral of clients to service agencies, structured programs for physical activity, smoking cessation, and nutrition.

**Health Topic(s) Addressed** • Heart disease, nutrition, physical activity, diabetes, high blood pressure, tobacco control.

**Geographic Area/Unit** • Rural, urban.

**Program Setting** • University/medical school.

**Target Population** • Black women.

**CHA Title** • Community health advisor.

**CHA Roles** • Health promotion/education, social support/counseling, community organizer.

**CHA Training** • 25-40 hours of initial training and 2-4 hours per month of inservice training.

**CHA Compensation** • None.

**Number of CHA's** • 100.

## Cardiovascular Disease

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*Evaluation Plan* • Yes.

*Methods Used to Recruit CHA's* • Word of mouth referral.

*Methods Used to Retain CHA's* • Graduation ceremony, program certificate.

214

**Program** • **Comprehensive High Blood Pressure Care for Young Black Men.**

**Contact** • Hill, Martha N.

**Agency** • The Johns Hopkins University School of Nursing, 1830 East Monument Street, Room 233, Baltimore, MD 21205-2100.  
(410) 614-1442.

**Program Dates** • June 1996–June 1999.

**Delivery Sites** • Homes, hospitals/private clinics, community agencies.

**Funding Source(s)** • Federal agency, Merck Pharmaceutical Company.

**Primary Purpose** • To evaluate the effectiveness of a comprehensive (educational, behavioral, and treatment) high blood pressure program in reducing blood pressure among inner-city black men aged 18–54 years.

**Services Offered** • Risk factor identification, free comprehensive clinical care, counseling, telephone follow-up, home visits with friends/family members who provide support.

**Health Topic(s) Addressed** • High blood pressure, stroke, heart disease, substance abuse.

**Geographic Area/Unit** • City and vicinity.

**Program Setting** • University/medical school.

**Target Population** • Inner-city black men aged 18–54 years.

**CHA Title** • Community health worker.

**CHA Roles** • Health promotion/education, social support/counseling, risk identification, transportation, case management, patient treatment/services.

**CHA Training** • More than 40 hours of initial training and 2–4 hours per month of inservice training.

**CHA Compensation** • \$8–\$12 per hour plus health insurance, sick/vacation days, tuition assistance, and retirement account.

**Number of CHA's** • 4.



## Cardiovascular Disease

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*Evaluation Plan* • Yes.

*Methods Used to Recruit CHA's* • Advertising, referrals from other CHA's, word-of-mouth referral, networking with other CHA programs, referrals from community groups and professionals.

*Methods Used to Retain CHA's* • Pay increase, career advancement.

*Methods Used to Retain Clients* • Study participants recruited from ongoing studies, from The Johns Hopkins Hospital Emergency Department, and by word of mouth.

*CHID Accession Number* • HE97P0670.

215

**Program** • Por Nuestra Salud Program, Puente a la Salud Program, 92701 Program.

**Contact** • Bracho, America; Rolon, Ilia.

**Agency** • Latino Health Access, 1518 North Broadway, Santa Ana, CA 92701-3907. (714) 542-7792.

**Program Dates** • 1993–continuing.

**Delivery Sites** • Homes, migrant centers/camps, program office.

**Funding Source(s)** • Private foundations.

**Primary Purpose** • To improve the quality of life and health status of Latino and Vietnamese adults residing in Orange County, California.

**Services Offered** • Home visits; health and nutrition education; food cooperative; classes in physical fitness, gardening, and cooking.

**Materials Used** • Spanish-language brochures on health topics published by the American Heart Association and the American Diabetes Association, curricula on diabetes management and cardiovascular disease prevention.

**Health Topic(s) Addressed** • Stroke, cholesterol education, heart disease, nutrition, physical activity, diabetes, high blood pressure.

**Geographic Area/Unit** • Urban, county.

**Program Setting** • Community-based agency.

**Target Population** • Latino and Vietnamese adults.

**CHA Title** • Lay health advisor.

**CHA Roles** • Health promotion/education, social support/counseling, risk identification, community organizing.

**CHA Training** • More than 40 hours of initial training and 2–4 hours per month of inservice training.

## Cardiovascular Disease

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*CHA Compensation* • \$6.00 per hour plus health insurance and sick/vacation days.

*Number of CHA's* • 10.

*Evaluation Plan* • Yes.

*Methods Used to Recruit CHA's* • Selection from participants in classes and other program activities.

*Methods Used to Retain CHA's* • Graduation ceremony, career advancement.

*Methods Used to Recruit Clients* • Referrals from seven community clinics, local churches, and the community at large.

*CHID Accession Number* • HE97P0881.



216

**Program** • Project Joy.

**Contact** • Becker, Diane.

**Agency** • Johns Hopkins Center for Health Promotion, 1830 East Monument Street, Room 8037, Baltimore, MD 21205. (410) 955-7781.

**Program Dates** • October 1995-continuing.

**Delivery Sites** • Churches.

**Funding Source(s)** • Centers for Disease Control and Prevention.

**Primary Purpose** • To reduce risk factors for cardiovascular disease among African American women by focusing on improved nutrition and physical activity and smoking cessation.

**Services Offered** • Either the self-help, standard, or enhanced intervention is offered. The self-help intervention consists of program materials and a one-time cardiovascular risk screening/education class; the standard intervention consists of the self-help intervention plus a nutrition and fitness kick-off retreat and weekly health education and aerobics classes led by lay instructors; the enhanced intervention consists of all the components of the standard intervention tailored to incorporate the faith beliefs and practices of the church.

**Materials Used** • Project Joy Manual, slides.

**Health Topic(s) Addressed** • Cholesterol screening/education, heart disease, nutrition, physical activity, high blood pressure, tobacco control, obesity.

**Geographic Area/Unit** • Urban.

**Program Setting** • Churches.

**Target Population** • Black women.

**CHA Title** • Lay instructor.

**CHA Roles** • Health promotion/education, social support/counseling.

## Cardiovascular Disease

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- CHA Training* • 8 hours or less of initial training and 2–4 hours per month of inservice training.
- CHA Compensation* • No hourly wage, expense reimbursement.
- Number of CHA's* • 12.
- Evaluation Plan* • Yes.
- Methods Used to Recruit CHA's* • Advertising, word of mouth referral, recruitment at screening programs.
- Methods Used to Retain CHA's* • Program certificate.

217

**Program** • Project Vida.

**Contact** • Koshewa, Connie; Avila, Sandra.

**Agency** • Project Vida, 3607 Rivera, El Paso, TX 79905. (915) 533-7057.

**Program Dates** • Continuing.

**Delivery Sites** • Homes, Project Vida.

**Funding Source(s)** • Nonprofit agency.

**Health Topic(s) Addressed** • Immunizations, nutrition, physical activity, diabetes, high blood pressure.

**Geographic Area/Unit** • Urban, neighborhood.

**Program Setting** • Community-based agency.

**Target Population** • Mexican Americans of all ages.

**CHA Title** • Americorps workers.

**CHA Roles** • Health promotion/education.

**CHA Training** • None.

**CHA Compensation** • Hourly wage plus health insurance and tuition assistance.

**Number of CHA's** • 3.

**Evaluation Plan** • No.

**CHID Accession Number** • HE97P0676.



218

**Program** • Sandtown–Winchester High Blood Pressure Control Program: Neighbors Knocking for Health.

**Contact** • Bone, Lee R.

**Agency** • The Johns Hopkins University School of Public Health, 624 North Broadway, Baltimore, MD 21205. (410) 955-6887.

**Program Dates** • September 1993–September 1997.

**Delivery Sites** • Homes, worksites.

**Funding Source(s)** • Federal government.

**Primary Purpose** • To control and reduce high blood pressure among black persons living in an urban community in Baltimore, Maryland.

**Services Offered** • Outreach.

**Materials Used** • Curriculum, training guide, brochure.

**Health Topic(s) Addressed** • High blood pressure.

**Geographic Area/Unit** • Urban, neighborhood.

**Program Setting** • University/medical school.

**Target Population** • Black adults living in an urban neighborhood in Baltimore, Maryland.

**CHA Title** • Community health advisor.

**CHA Roles** • Health promotion/education, social support/counseling, case management.

**CHA Training** • 25–40 hours of initial training and 2–4 hours per month of inservice training.

**CHA Compensation** • Health insurance, health/vacation days, tuition assistance, retirement account.

**Number of CHA's** • 4.

*Evaluation Plan* • Yes.

*Methods Used to Recruit CHA's* • Advertising, referrals from other CHA's, word-of-mouth referrals, networking with other CHA programs, referrals from community groups and professionals, community advisories.

*Methods Used to Retain CHA's* • Graduation ceremony, pay increase, program certificate.

*CHID Accession Number* • HE97P0619.

219

**Program** • South Carolina Strike Out Stroke (SOS) Project.

**Contact** • Wright-Mallozry, Barbara.

**Agency** • South Carolina Department of Health and Environmental Control, Center for Health Promotion, SOS Project, P.O. Box 101106, Mills/Jarrett Complex, Columbia, SC 29211. (803) 737-6054.

**Program Dates** • October 1996–September 1997.

**Delivery Sites** • Religious organizations, health maintenance organizations, community centers, public health clinics, churches, barber and beauty shops and schools.

**Funding Source(s)** • Federal and state government agencies.

**Primary Purpose** • To reduce risk factors for stroke among black adults in rural South Carolina.

**Services Offered** • Training to community members who want to spread the word about stroke risk reduction.

**Materials Used** • *Guidelines for Working with Black Churches, Guidelines for African American Church-Based Health Promotion, Reaching African Americans Through Media Channels, The Strike Out Stroke Beauty and Barber Shop Health Intervention Manual, Beauty Shop Talk, Barber Shop Talk.*

**Health Topic(s) Addressed** • Stroke, cholesterol screening/education, heart disease, nutrition, physical activity, diabetes, high blood pressure, tobacco use.

**Geographic Area/Unit** • Rural, state.

**Program Setting** • Community-based agency, state health department, local health department, religious institution.

**Target Population** • Black adults in rural South Carolina.

**CHA Title** • Community health advisor.

**CHA Roles** • Health promotion/education, social support/counseling, risk identification, community organizing.



*CHA Training* • No initial training; 2–4 hours per month of inservice training.

*CHA Compensation* • None.

*Evaluation Plan* • Yes.

*Number of CHA's* • 12.

*Methods Used to Recruit CHA's* • Word-of-mouth referral.

*Methods Used to Retain CHA's* • Annual awards ceremony.

*CHID Accession Number* • HE97P0499.

220

**Program** • Women's Cancer and Cardiovascular Disease Control Project.

**Contact** • Nixon, Daniel W.

**Agency** • Hollings Cancer Center, Prevention and Control Department,  
171 Ashley Avenue, Charleston, SC 29425-2850. (803) 792-0700.

**Program Dates** • June 1995–continuing.

**Delivery Sites** • Homes, community centers, public health clinics, hospitals/private clinics.

**Funding Source(s)** • Centers for Disease Control and Prevention.

**Primary Purpose** • To increase risk reduction screening and compliance with nutrition guidelines among women in South Carolina.

**Services Offered** • Identification of risk factors by a primary care provider followed by in-depth counseling and education by a CHA.

**Materials Used** • Curriculum, video, training guide, teaching aid.

**Health Topic(s) Addressed** • Stroke, cholesterol screening/education, heart disease, nutrition, physical activity, cancer, diabetes, high blood pressure, osteoporosis, tobacco use.

**Geographic Area/Unit** • State.

**Program Setting** • Community-based agency, hospital/medical clinic/health maintenance organization.

**Target Population** • Women aged 20 years and older.

**CHA Title** • Volunteer adjunct researcher.

**CHA Roles** • Health promotion/education, social support/counseling.

**CHA Training** • 8 hours or less of initial training and 2–4 hours per month of inservice training.

**CHA Compensation** • None.

*Number of CHA's* • 60.

*Evaluation Plan* • Survey administered to participants at project entry and at 6, 12, 18, 24, and 30 months following entry as well as regular telephone calls for support and to evaluate behavior change.

*Methods Used to Recruit CHA's* • Referrals from community groups and professionals.

*Methods Used to Retain CHA's* • Program certificate.

*Methods Used to Recruit Clients* • Participants are drawn from the seven practices of the South Carolina Primary Care Research Consortium.

*CHID Accession Number* • HE97P1041.





## Diabetes

221

**Program** • **Diabetes: Check It Out!**

**Contact** • Sims, Reina

**Agency** • Central Ohio Diabetes Association, 1580 King Avenue, Columbus, OH 43212. (614) 486-7124.

**Program Dates** • July 1997–continuing.

**Delivery Sites** • Religious organizations, health maintenance organizations, community centers, public health clinics, hospitals/private clinics.

**Funding Source(s)** • State government agency, local community and medical foundations.

**Primary Purpose** • To provide diabetes screening, education, and support services to minority populations.

**Methods Employed** • Uses the church setting as a site for diabetes education, quarterly screenings, monthly support group meetings, diabetes education classes, and individual counseling sessions with a certified diabetes educator.

**Health Topic(s) Addressed** • Diabetes, heart disease, nutrition, physical activity, kidney disease, high blood pressure.

**Geographic Area/Unit** • City and vicinity.

**Program Setting** • Religious organizations, health maintenance organizations, community centers, public health clinics, hospitals/private clinics.

**Target Population** • Blacks, Asian Americans, Native Americans, and Hispanics of all ages.

**CHA Title** • Community health advisor.

**CHA Roles** • Health promotion/education, risk identification, outreach, client advocacy, nonclinical treatment/services.

**CHA Training** • 8 hours or less of initial training and 2–4 hours per month of inservice training.

## Diabetes

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*CHA Compensation* • No hourly wage; commuter subsidy and quarterly stipends are provided.

*Evaluation Plan* • Yes.

*Methods Used to Recruit CHA's* • Advertising, referrals from other CHA's, word-of-mouth referral, networking with other CHA programs, referrals from community groups and professionals.

*Methods Used to Retain CHA's* • Program certificate, recognition at annual meeting.

*CHID Accession Number* • HE97P1042.



222

**Program** • Neighborhood Health Clinics, Inc.

**Contact** • Brennan, Laura.

**Agency** • Neighborhood Health Clinics, Inc., 4945 Northeast Seventh Street, Portland, OR 97211. (503) 288-5995.

**Program Dates** • Continuing.

**Delivery Sites** • Schools, religious organizations, homes, community centers.

**Funding Source(s)** • Local government agency, area health education centers, American Diabetes Association (ADA).

**Primary Purpose** • To increase diabetes awareness and knowledge among low-income residents of north and northeast Portland, Oregon, especially uninsured persons.

**Services Offered** • Information and educational materials, referrals to health care providers, peer support, exercise and cooking classes.

**Methods Employed** • Disseminates ADA posters and brochures, manages information tables at community centers, facilitates presentations at schools and churches, maintains a multilanguage print and video diabetes library.

**Materials Used** • Posters, brochures, videotapes.

**Health Topic(s) Addressed** • Diabetes.

**Geographic Area/Unit** • Urban, neighborhood.

**Program Setting** • Community-based agency.

**Target Population** • Low-income residents of north and northeast Portland, Oregon, especially uninsured persons.

**CHA Title** • Community lay health promoter.

**CHA Roles** • Health promotion/education, social support/counseling, case management, community organizing.

## Diabetes

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*CHA Training* • 8 hours or less of initial training and 2–4 hours per month of inservice training.

*CHA Compensation* • No hourly wage; expense reimbursement, child care, and a commuter subsidy are provided.

*Number of CHA's* • 16.

*Evaluation Plan* • Yes.

*Methods Used to Recruit CHA's* • Referrals from other CHA's, word-of-mouth referral, referrals from community groups and professionals.

*Methods Used to Retain CHA's* • Program certificate.

*CHID Accession Number* • HE97P0750.

223

**Program** • **Primary Care Diabetes Management Program.**

**Contact** • Hurley, Judith.

**Agency** • New Mexico Department of Health, Diabetes Control Program, Health Promotion Bureau, P.O. Box 26110, Santa Fe, NM 87502-6110. (505) 827-2453.

**Program Dates** • July 1994—continuing.

**Delivery Sites** • Community health clinic.

**Funding Source(s)** • State legislature.

**Primary Purpose** • To assist Hispanics and members of the Navajo community who are living with diabetes to manage the disease.

**Services Offered** • Diabetes and nutrition education, case management, screening, individual counseling, support group meetings, quality assurance.

**Methods Employed** • Home visits, phone and mail contact, outreach.

**Health Topic(s) Addressed** • Diabetes, nutrition.

**Geographic Area/Unit** • Four communities.

**Program Setting** • State health department, hospital/medical clinic.

**Target Population** • Native American and Hispanic adults with diabetes and children and family members at risk for diabetes who reside in isolated, rural areas of New Mexico.

**CHA Title** • Lay health advisor.

**CHA Roles** • Outreach, health education/promotion, risk assessment, social support/counseling.

**CHA Compensation** • \$6–\$10 per hour plus fringe benefits.

**Number of CHA's** • 11.



## Diabetes

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*Evaluation Plan* • Yes.

*CHID Accession Number* • HE96P0175.

## Health Promotion and Disease Prevention

224

**Program** • Community Health Advisor Network.

**Contact** • Dennis, Hattie; Johnson, Freddie.

**Agency** • Ruleville Health Department, Ruleville, MS 38771.  
(610) 756-4881.

**Program Dates** • 1995--continuing.

**Delivery Sites** • Schools, religious organizations, homes, community facilities, public health clinics.

**Funding Source(s)** • Private foundation.

**Primary Purpose** • To promote health and prevent disease.

**Materials Used** • Video, brochure, teaching aid.

**Health Topic(s) Addressed** • Cancer, diabetes, family planning, heart disease, high blood pressure, HIV/AIDS, nutrition, pregnancy/prenatal care, physical activity, adolescent sexual behavior, tobacco use, stroke, substance abuse, violence.

**Geographic Area/Unit** • Rural communities.

**Program Setting** • State health department, local health department, religious institution, hospital/medical clinic, school/school system.

**Target Population** • Persons of all ages.

**CHA Title** • Community health advisor.

**CHA Roles** • Outreach, health promotion/education, risk assessment, social support/counseling, community advocacy, transportation.

**CHA Training** • 40 hours of initial training and 3 hours per month of inservice training.

**CHA Compensation** • None.

**Number of CHA's** • 3.

## Health Promotion and Disease Prevention

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*Number of Clients Served in 12 Months* • 50.

*Evaluation Plan* • No.

*Methods Used to Recruit CHA's* • Contacts at schools and religious institutions.

*Methods Used to Retain CHA's* • Frequent reminders that they are doing important work, support/encouragement.

*Methods Used to Recruit Clients* • One-on-one contacts in the community, flyers on health and nutrition.

*Methods Used to Retain Clients* • Home visits and phone contact.

*CHID Accession Number* • HE96P0168.



225

**Program** • Community Health Advisor Network.

**Contact** • Dillon, Patricia.

**Agency** • Leland Community Health Advisor, 105 5th Street, Leland, MS 38756. (601) 686-2322.

**Program Dates** • December 1991–continuing.

**Delivery Sites** • Homes, community facilities, public health clinics.

**Funding Source(s)** • Nonprofit agency.

**Primary Purpose** • To provide health education, advice, assistance, and referrals.

**Materials Used** • Training guide, resource directory.

**Health Topic(s) Addressed** • High blood pressure, nutrition, stroke.

**Geographic Area/Unit** • Communities.

**Program Setting** • State health department.

**Target Population** • Black persons of all ages.

**CHA Title** • Community health advisor.

**CHA Roles** • Outreach, health promotion/education, client advocacy, social support/counseling, transportation.

**CHA Training** • 40 hours of initial training and 3 hours per month of inservice training.

**CHA Compensation** • None.

**Number of CHA's** • 12.

**Number of Clients Served in 12 Months** • 50.

**Evaluation Plan** • Yes.

## Health Promotion and Disease Prevention

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*Methods Used to Recruit CHA's* • Advertising, referrals from other CHA's, word of mouth.

*Methods Used to Retain CHA's* • Monthly meetings to air ideas/problems/frustrations.

*Methods Used to Recruit Clients* • Word of mouth.

*Methods Used to Retain Clients* • Adherence to program objectives.

*CHID Accession Number* • HE96P0169.

226

**Program** • Community Health Advocates Program.

**Contact** • Rodney, Marilyn.

**Agency** • Center for Healthy Communities, 140 East Monument Avenue,  
Dayton, OH 45402. (513) 873-1114.

**Program Dates** • September 1992–continuing.

**Delivery Sites** • Food pantries and meal sites, health centers, senior centers,  
community centers.

**Funding Source(s)** • U.S. Department of Education, Ohio Department of Health.

**Primary Purpose** • To improve the health of community members by linking them with  
community resources.

**Services Offered** • Health information and materials, links with resources, support and  
follow-up.

**Materials Used** • Curriculum, videotape, health questionnaire, brochures, posters,  
resource directory.

**Health Topic(s) Addressed** • Health promotion and disease prevention.

**Geographic Area/Unit** • Urban.

**Program Setting** • Community/academic partnership.

**Target Population** • Urban residents of all ages.

**CHA Title** • Community health advocate.

**CHA Roles** • Outreach, health promotion/education, risk assessment, client and  
community advocacy, transportation, social support/counseling.

**CHA Training** • 120 hours of initial training and 5 hours per month of inservice  
training.

**CHA Compensation** • Depends on grant provisions.

**Number of CHA's** • 10.



## Health Promotion and Disease Prevention

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*Number of Clients Served in 12 Months* • 1,600.

*Evaluation Plan* • Yes.

*Methods Used to Recruit CHA's* • Community presentations, networking, word-of-mouth referrals.

*Methods Used to Retain CHA's* • Opportunities for involvement in decision making and leadership, pay/benefits increase.

*Methods Used to Recruit Clients* • Referrals from community agencies and workers, contacts in the community, word of mouth.

*Methods Used to Retain Clients* • Periodic client contact, building a relationship of mutual respect.

*CHID Accession Number* • HE96P0957.

227

**Program** • Community Health Outreach System.

**Contact** • Manley, Marcia.

**Agency** • Solano Coalition for Better Health, 1735 Enterprise Drive, MS 3-220, Fairfield, CA 94533. (707) 421-4700.

**Program Dates** • January 1996–continuing.

**Delivery Sites** • Worksites, health maintenance organization, homes, community centers.

**Funding Source(s)** • Local government agency, Kaiser Permanente, Robert Wood Johnson Foundation.

**Primary Purpose** • To improve the status of project participants through individual, family, and neighborhood interventions.

**Project Goals** • Improve the health status of children, improve rates of early cancer detection in women through increased use of Pap tests and mammogram, promote effective utilization of the Medi-Cal managed care system, increase residents' involvement in community decisions that affect their health.

**Health Topic(s) Addressed** • Child health, family planning, HIV/AIDS, mental health, pregnancy/prenatal care, immunizations, nutrition, substance abuse, breast and cervical cancer, diabetes, adolescent sexual behavior, tobacco use.

**Geographic Area/Unit** • Urban, neighborhood.

**Program Setting** • Local health department.

**Target Population** • Neighborhood residents of all ages.

**CHA Title** • Outreach worker.

**CHA Roles** • Health promotion/education, social support/counseling, risk identification, case management, community organizing.

**CHA Training** • More than 40 hours of initial training and more than 4 hours per month of inservice training.

## Health Promotion and Disease Prevention

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*CHA Compensation* • \$10.00 per hour plus health insurance, sick/vacation days, tuition assistance, pension plan, and retirement account.

*Number of CHA's* • 8.

*Evaluation Plan* • Yes.

*Methods Used to Recruit CHA's* • Referrals from other CHA's, word-of-mouth referral, networking with other CHA programs, referrals from community groups and professionals.

*Methods Used to Retain CHA's* • Graduation ceremony, program certificate, academic credit.

*CHID Accession Number* • HE97P1043.



228

**Program** • Decker Family Development Center.

**Contact** • Ahern, Mary Frances.

**Agency** • Decker Family Development Center, 633 Brady Avenue, Barberton, OH 44203. (330) 848-4264.

**Program Dates** • September 1990–continuing.

**Delivery Sites** • Schools, homes, community facilities, public health clinics, hospitals/medical clinics, facilities of collaborating agencies.

**Funding Source(s)** • Federal agency, state government agency, local government agency, nonprofit, private foundation, private donations.

**Primary Purpose** • To provide comprehensive medical, educational, social, and mental health support services to predominantly low-income families in Barberton, Ohio.

**Services Offered** • Health care, nutrition education, mental health services, case management/family support, outreach.

**Materials Used** • Brochures on nutrition and women's and children's health issues.

**Health Topic(s) Addressed** • Cancer, cholesterol screening/education, diabetes, family planning, high blood pressure, HIV/AIDS, injuries, nutrition, pregnancy/prenatal care, physical activity, adolescent sexual behavior, tobacco use, substance abuse, violence.

**Geographic Area/Unit** • Urban, county.

**Program Setting** • Community-based agency, state health department, local health department, hospital/medical clinic, school/school system.

**Target Population** • Low-income residents of all ages.

**CHA Title** • Outreach worker.

**CHA Roles** • Outreach, health promotion/education, risk assessment, client/community advocacy, patient treatment/services, social support/counseling, transportation.

## Health Promotion and Disease Prevention

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*CHA Training* • 40 hours of initial training and 3 hours per month of inservice training.

*CHA Compensation* • \$9.00 per hour plus medical/dental insurance.

*Number of CHA's* • 5.

*Number of Clients Served in 12 Months* • 125 families.

*Evaluation Plan* • Yes.

*Methods Used to Recruit CHA's* • Draw on past participants in program, collaborate with the University of Akron to place students as CHA's, network with other community agencies.

*Methods Used to Retain CHA's* • Attractive pay/benefits, flexible work schedule to accommodate personal/family needs, educational opportunities.

*Methods Used to Recruit Clients* • Word-of-mouth referral; referrals from other community agencies, families, and individuals.

*Methods Used to Retain Clients* • Build clients' self-esteem, meet clients' needs/goals.

*CHID Accession Number* • HE97P0500.

229

**Program** • English, Medical Services, Parenting, and Work Experience.

**Contact** • Shimazu, Susan.

**Agency** • Asian Pacific Health Care Venture, 300 West Cesar Chavez Avenue, Los Angeles, CA 90012. (213) 346-0370.

**Program Dates** • January 1996–December 1996.

**Delivery Sites** • Homes, community centers, neighborhoods.

**Funding Source(s)** • Private foundation.

**Primary Purpose** • To help Asian American women with the English language, medical services, parenting, and work experience.

**Health Topic(s) Addressed** • Pregnancy/prenatal care, immunizations.

**Geographic Area/Unit** • Urban, county.

**Program Setting** • Community-based agency.

**Target Population** • Asian American women of Chinese, Thai, and Cambodian descent, aged 20–64 years.

**CHA Title** • Community health advisor.

**CHA Roles** • Health promotion/education.

**CHA Training** • 25–40 hours of initial training; inservice training varies.

**CHA Compensation** • Expense reimbursement, tuition assistance.

**Number of CHA's** • 25.

**Evaluation Plan** • Yes.

**Methods Used to Recruit CHA's** • Referrals from other CHA's, word-of-mouth referral, referrals from other community groups and professionals.



## Health Promotion and Disease Prevention

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*Methods Used to* • Graduation ceremony, program certificate, scholarships.  
*Retain CHA's*

*CHID Accession Number* • HE97P0684.

230

**Program** • 4Sight: The West Philadelphia Prevention of Blindness Project.

**Contact** • Johnson, Pamela E.

**Agency** • University of Pennsylvania School of Medicine, Scheie Eye Institute, 51 North 39th Street, Philadelphia, PA 19104. (215) 662-8140.

**Program Dates** • April 1997–continuing.

**Delivery Sites** • Religious organizations, community centers.

**Funding Source(s)** • Federal agency, private foundation.

**Primary Purpose** • To reduce the risk of blindness among black adults.

**Health Topic(s) Addressed** • Ocular disorders, diabetes.

**Geographic Area/Unit** • City and vicinity.

**Program Setting** • Community-based agency, religious institution, hospital/medical clinic/health maintenance organization, university/medical school.

**Target Population** • Black adults.

**CHA Title** • Community health advisor.

**CHA Roles** • Health promotion/education, social support/counseling, risk identification.

**CHA Training** • 8 hours or less of initial training and less than 2 hours per month of inservice training.

**CHA Compensation** • None.

**Number of CHA's** • 4.

**Methods Used to Recruit CHA's** • Referrals from community groups and professionals.

**Methods Used to Retain CHA's** • Graduation ceremony, program certificate.

**CHID Accession Number** • HE97P0675.

231

**Program** • **HealthReach.**

**Contact** • Hadden, Bonnie.

**Agency** • St. Mary's Hospital, 265 Warwick Avenue, Rochester, NY 14611.  
(716) 464-5822.

**Program Dates** • September 1991–continuing.

**Delivery Sites** • Schools, community centers, hospital, homeless shelters, mobile medical unit.

**Funding Source(s)** • Federal agency, state government agency, local government, donations.

**Primary Purpose** • To make health care services more accessible to vulnerable people.

**Services Offered** • CHAs provide health education, aid clients in keeping appointments, recruit women into programs, and work with women to improve birth outcomes.

**Materials Used** • Variety of curricula, videos, brochures, training guides, teaching aids, and resource directories.

**Health Topic(s) Addressed** • Child health, family planning, HIV/AIDS, mental health, pregnancy/prenatal care, violence, cholesterol screening/education, immunizations, nutrition, physical activity, substance abuse, diabetes, injuries, adolescent sexual behavior, tobacco use.

**Geographic Area/Unit** • Urban, county.

**Program Setting** • Community-based agency, local health department, hospital, school/school system.

**Target Population** • Vulnerable black, Asian American, and Hispanic persons of all ages.

**CHA Title** • Peer educator, community health educator, outreach worker.

**CHA Roles** • Health promotion/education, social support/counseling, case management, community organizing, patient treatment/services, transportation.



*CHA Training* • 25–40 hours of initial training and 2–4 hours per month of inservice training.

*CHA Compensation* • Variable hourly wage plus health insurance, sick/vacation days, expense reimbursement, pension plan, and retirement account.

*Number of CHA's* • 37.

*Evaluation Plan* • Yes.

*Methods Used to Recruit CHA's* • Advertising, referrals from other CHA's, word-of-mouth referral, networking with other CHA programs, referrals from community groups and professionals.

*Methods Used to Retain CHA's* • Program certificate, theater tickets, continuing education.

*CHID Accession Number* • HE97P0671.

232

**Program** • Health Works for Women.

**Contact** • Campbell, Marci K.

**Agency** • Center for Health Promotion and Disease Prevention, University of North Carolina, Campus Box 7400-Nutrition, Chapel Hill, NC 27599. (919) 966-7230.

**Program Dates** • October 1993–continuing.

**Delivery Sites** • Worksites.

**Funding Source(s)** • Centers for Disease Control and Prevention.

**Primary Purpose** • To teach women to make healthy changes in their lives and pass along this information to their coworkers.

**Materials Used** • Training guides on reducing stress, healthy eating, fitness, and weight loss; audiotape on reducing stress.

**Health Topic(s) Addressed** • Nutrition, physical activity, breast and cervical cancer, tobacco use.

**Geographic Area/Unit** • Rural, multicounty.

**Program Setting** • Worksites, university/medical school.

**Target Population** • Women aged 18–64 years.

**CHA Title** • Natural helper.

**CHA Roles** • Health promotion/education, social support/counseling.

**CHA Training** • 9–24 hours of initial training and less than 2 hours per month of inservice training.

**CHA Compensation** • None.

**Number of CHA's** • 40.

**Evaluation Plan** • Yes.

**Methods Used to Recruit CHA's** • Advertising, word-of-mouth referral.

*Methods Used to* • Graduation ceremony, program certificate.  
*Retain CHA's*

*CHID Accession Number* • HE97P0885.



233

**Program** • **Healthy Families.**

**Contact** • Williams, Patricia.

**Agency** • Health Education Center, Fifth Avenue Place, Suite 1811, Pittsburgh, PA 15222. (412) 392-3180.

**Program Dates** • 1987–1991.

**Funding Source(s)** • Richard K. Mellon Foundation, United Way of Allegheny County.

**Primary Purpose** • To provide education in parenting skills and health to parents in high-risk communities.

**Services Offered** • Weekly sessions in topics such as self-esteem, goal setting, positive role modeling, safe environment, discipline techniques, and nutrition.

**Methods Employed** • Six two-hour sessions taught by lay leaders.

**Materials Used** • Take-home kit of topic-related materials, samples, and pamphlets.

**Health Topic(s) Addressed** • Safe environment, nutrition.

**Target Population** • Low-income parents of children aged 12 years and younger.

**CHA Title** • Lay leader.

**CHA Roles** • Health education/promotion, support, identification and recruitment of other CHA's.

**Evaluation Plan** • Yes.

**Methods Used to Recruit CHA's** • Referrals from other CHA's, word-of-mouth referral.

**Methods Used to Recruit Clients** • Contracting with agencies and organizations whose clients include the target population, advertising, presentations to religious/community groups.

**CHID Accession Number** • HE89P0314.

234

**Program** • Panola County Outreach Organization: Quitman County Community Health Advisors.

**Contact** • Keys, Liza.

**Agency** • Mississippi State Department of Health, District I Health Office, 240 Tower Drive, Batesville, MS 38606. (601) 563-5603.

**Program Dates** • February 1994—continuing.

**Delivery Sites** • Schools, worksites, religious organizations, homes, community centers, public health clinics, hospitals/private clinics.

**Funding Source(s)** • Donations from civic organization.

**Primary Purpose** • To provide community health education and outreach.

**Services Offered** • Health education, outreach, and counseling; community health evaluations and opinion surveys; nursing home visits; annual health fair.

**Materials Used** • Video, brochure, CHA resource directory, scrapbook.

**Health Topic(s) Addressed** • Child health, HIV/AIDS, mental health, pregnancy/prenatal care, stroke, violence, arthritis, cholesterol screening/education, heart disease, immunizations, nutrition, physical activity, substance abuse, cancer, diabetes, high blood pressure, injuries, tobacco use.

**Geographic Area/Unit** • State.

**Program Setting** • Community-based agency, state health department, local health department, school/school system.

**Target Population** • Mississippi residents of all ages.

**CHA Title** • Community health advisor.

**CHA Roles** • Health promotion/education, social support/counseling, risk identification, community organizing, transportation.

**CHA Training** • 25–40 hours of initial training and 2–4 hours per month of inservice training.

## Health Promotion and Disease Prevention

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*CHA Compensation* • No hourly wage; expenses sometimes reimbursed.

*Number of CHA's* • 38.

*Methods Used to Recruit CHA's* • Advertising, referrals from other CHA's, word-of-mouth referral, networking with other CHA programs, referrals from community groups and professionals.

*Methods Used to Retain CHA's* • Program certificate, luncheons, other ways to demonstrate appreciation.

*CHID Accession Number* • HE97P0685.



235

**Program** • **Peer Educator Project.**

**Contact** • Keju-Johnson, Darlene.

**Agency** • Youth to Youth in Health, P.O. Box 3149, Majuro, Marshall Islands 96960. (692) 625-3098.

**Program Dates** • June 1986–continuing.

**Delivery Sites** • Schools, worksites, religious organizations, community facilities, public health clinics, hospitals/medical clinics.

**Funding Source(s)** • Ministry of Health Services, FHP Foundation.

**Primary Purpose** • To train peer educators aged 13–25 years to lead health education and outreach activities, counsel youth clients, and share with elementary, high school, and out-of-school youth information on health topics of concern to adolescents and the community at large.

**Services Offered** • Three-pronged program emphasizing appreciation of culture, knowledge of health, and understanding of ecumenical religious values and responsibility.

**Methods Employed** • Outreach programs incorporating skits, music, dance, puppet shows, slides, and films.

**Materials Used** • Brochures on HIV/AIDS, suicide, and other health issues.

**Health Topic(s) Addressed** • Family planning, HIV/AIDS, nutrition, pregnancy/prenatal care, adolescent sexual behavior, tobacco use, substance abuse.

**Geographic Area/Unit** • Marshall Islands.

**Program Setting** • Chartered nonprofit organization. Youth to Youth in Health is a membership organization of young persons in the Marshall Islands who have attended a Youth Health Leadership Seminar, actively participate in outreach programs and meetings, and pay membership dues.

**Target Population** • Marshall Islanders of all ages.

**CHA Title** • Peer educator.

## Health Promotion and Disease Prevention

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- CHA Roles* • Outreach, health promotion/education, social support/counseling.
- CHA Training* • 3 weeks of initial training and more than 10 hours per month of inservice training.
- CHA Compensation* • \$150 monthly stipend.
- Number of CHA's* • 7 paid staff, 6 full-time volunteers, and more than 500 part-time volunteers throughout the Marshall Islands.
- Evaluation Plan* • Yes.
- Methods Used to Recruit CHA's* • Outreach education programs in schools/communities, word of mouth.
- Methods Used to Retain CHA's* • Ongoing outreach programs in the community, varied activities and responsibilities.
- Methods Used to Recruit Clients* • Advertising in electronic media, outreach education programs, word of mouth.
- Methods Used to Retain Clients* • Involving clients in outreach activities, provision of clinic services.
- CHID Accession Number* • HE96P0176.

236

**Program** • **Peer Health Education Project.**

**Contact** • Connor, Ann.

**Agency** • Georgia Nurses Foundation, Inc., 1362 West Peachtree Street, NW, Atlanta, GA 30309-2904. (404) 876-4624.

**Program Dates** • October 1993–continuing.

**Delivery Sites** • Community facilities.

**Funding Source(s)** • Department of Health and Human Services, state government agency, private foundation.

**Primary Purpose** • To increase health education, knowledge, skills, self-confidence, and self-esteem among community members; increase the number of persons who are reached, treated, and educated; and empower the community.

**Services Offered** • Classes in skill building and health topics.

**Methods Employed** • No formal, ongoing program. Follows the 12-step recovery program.

**Materials Used** • Resource directory listing alcohol and drug treatment programs, handouts on listening skills.

**Health Topic(s) Addressed** • Participant-determined topics, including substance abuse, violence, outreach, and communication skills.

**Geographic Area/Unit** • City.

**Program Setting** • Community-based agency.

**Target Population** • Homeless black persons of all ages.

**CHA Title** • Peer health educator.

**CHA Roles** • Outreach, health promotion/education, client/community advocacy.

**CHA Compensation** • None.

**Number of CHA's** • 10 each session.



## Health Promotion and Disease Prevention

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*Evaluation Plan* • Yes.

*Methods Used to Recruit CHA's* • Selection from program participants.

*Methods Used to Recruit Clients* • Outreach by CHA's.

*CHID Accession Number* • HE96P0171.

237

**Program** • **Platicamos Salud (Department of Health Promotion and Disease Prevention).**

**Contact** • Gomez-Murphy, Maria.

**Agency** • Mariposa Community Health Center, 1852 North Mastick Way, Nogales, AZ 85621. (520) 281-2860.

**Program Dates** • October 1991–continuing.

**Delivery Sites** • Schools, worksites, religious organizations, homes, community centers, hospitals/private clinics, laundromats, retail stores.

**Funding Source(s)** • Federal agency, state government agency, private foundations.

**Primary Purpose** • To provide health education, referral to needed services, and patient advocacy in a holistic, family-centered fashion.

**Services Offered** • Health education and home visits for pregnant adolescents and women; education about cancer prevention and support groups for cancer survivors and their families; HIV/AIDS prevention information; HIV antibody testing and medical and support services for HIV-positive persons and their families; teen talk line for information and referrals; tobacco control program for teens, pregnant women, and mothers and their partners.

**Materials Used** • Training curricula: “Health Start” and “Opening Doors for Healthier Families.”

**Health Topic(s) Addressed** • Child health, family planning, HIV/AIDS, mental health, pregnancy/prenatal care, violence, immunizations, nutrition, physical activity, cancer, high blood pressure, adolescent sexual behavior, tobacco use, hearing/vision testing, breastfeeding, child development, safety, child high-risk conditions.

**Geographic Area/Unit** • Rural, county.

**Program Setting** • Community health center.

**Target Population** • Mexican American adolescents and adults.

**CHA Title** • Promotora (lay health promoter).

## Health Promotion and Disease Prevention

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*CHA Roles* • Health promotion/education, social support/counseling, risk identification, case management, community organizing, transportation.

*CHA Training* • 25–40 hours of initial training and more than 4 hours per month of inservice training.

*CHA Compensation* • \$6.50 per hour plus health insurance, sick/vacation days, and pension plan.

*Number of CHA's* • 14.

*Evaluation Plan* • Client satisfaction questionnaire, quarterly and annual reviews of promotoras' caseloads, annual field audits of promotoras' performance.

*Methods Used to Recruit CHA's* • Advertising, referrals from other CHA's, word-of-mouth referral, referrals from other community groups and professionals.

*Methods Used to Retain CHA's* • Graduation ceremony, program certificate, career advancement.

*CHID Accession Number* • HE97P0678.



238

**Program** • Project REACH Street Outreach Program.

**Contact** • Fairley, Jeffrey.

**Agency** • Covenant House, 1000 North Rampart Street, New Orleans, LA 70116. (504) 523-3292.

**Program Dates** • Continuing.

**Delivery Sites** • Schools, worksites, religious organizations, community centers.

**Funding Source(s)** • Businesses.

**Primary Purpose** • To assist homeless persons to return to society and lead fulfilling, successful lives.

**Services Offered** • Case management, clothing/blankets, first aid, information and referral, employment information, meal tickets/food, access to substance abuse treatment, transportation, mental health counseling/referral, housing assistance.

**Health Topic(s) Addressed** • Mental health, pregnancy, prenatal care, violence, nutrition, adolescent sexual behavior.

**Geographic Area/Unit** • City and vicinity.

**Program Setting** • Community-based agency.

**Target Population** • Homeless adolescents and adults.

**CHA Title** • Community health advisor.

**CHA Roles** • Health promotion/education, social support/counseling, case management, patient treatment/services, transportation.

**CHA Training** • More than 40 hours of initial training.

**CHA Compensation** • \$8.00 per hour plus health insurance, sick/vacation days, and expense reimbursement.

**Number of CHA's** • 6.

## Health Promotion and Disease Prevention

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*Methods Used to Recruit CHA's* • Advertising, referrals from other CHA's, word-of-mouth referral, networking with other CHA programs, referrals from community groups and professionals.

*Methods Used to Retain CHA's* • Pay increase, career advancement.

*CHID Accession Number* • HE97P0677.

239

**Program** • Promotora Project of Luna County, New Mexico.

**Contact** • Otero, Guadalupe.

**Agency** • Columbus Health Care Organization, P.O. Box 350, Columbus, NM 88029. (505) 531-2699.

**Program Dates** • January 1995–continuing.

**Delivery Sites** • Schools, worksites, homes, community facilities, migrant centers/camps.

**Funding Source(s)** • State government agency, nonprofit agency, private donations.

**Primary Purpose** • To promote good health.

**Services Offered** • Referrals to local and state services, home visits, workshops, resource materials, needs assessment.

**Materials Used** • Training guide, handouts on safe use of pesticides.

**Health Topic(s) Addressed** • Diabetes, family planning, high blood pressure, HIV/AIDS, tobacco use.

**Geographic Area/Unit** • Rural, county.

**Program Setting** • Community-based agency.

**Target Population** • Rural residents of Luna County, New Mexico.

**CHA Title** • Promotora (lay health promoter).

**CHA Roles** • Outreach, health promotion/education, community advocacy.

**CHA Training** • 40 hours of initial training and 15–25 hours per month of inservice training.

**CHA Compensation** • \$5.00 per hour.

**Number of CHA's** • 6.



## Health Promotion and Disease Prevention

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*Number of Clients Served in 12 Months* • 750.

*Methods Used to Recruit CHA's* • Word-of-mouth referral, community education activities.

*Methods Used to Retain CHA's* • Regular evaluation and feedback, biannual conflict resolution activity.

*Methods Used to Recruit Clients* • One-on-one outreach.

*Methods Used to Retain Clients* • Home visits, one-on-one outreach.

*CHID Accession Number* • HE96P0956.

240

**Program** • Reducing the Socio-Cultural Barriers to Primary Care for Southeast Asian Residents of Shasta County, California.

**Contact** • Germano, C. Dean.

**Agency** • Shasta Community Health Center, 2630 Breslauer Way, Redding, CA 96001. (916) 246-5704.

**Program Dates** • January 1994–December 1996.

**Delivery Sites** • Homes, community health center, public health clinic, hospitals/private clinics.

**Funding Source(s)** • Federal agency, state government agency, local government agency, grants.

**Primary Purpose** • To improve access to and use of appropriate primary care services available to the isolated Southeast Asian community in Redding, California.

**Services Offered** • Interpreter service for non-English speakers, home visits on family health issues.

**Materials Used** • Brochure and video in the Mien language.

**Health Topic(s) Addressed** • Alzheimer's disease, child health, family planning, HIV/AIDS, mental health, arthritis, cholesterol screening/education, heart disease, immunizations, nutrition, substance abuse, breast and cervical cancer, diabetes, high blood pressure, osteoporosis, adolescent sexual behavior, tobacco use.

**Geographic Area/Unit** • City and vicinity.

**Program Setting** • Community-based agency.

**Target Population** • Asian Americans of Laotian descent.

**CHA Title** • Community health worker.

**CHA Roles** • Health promotion/education, social support/counseling, risk identification, case management, patient treatment/services.

## Health Promotion and Disease Prevention

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*CHA Training* • 25–40 hours of initial training and less than 2 hours per month of inservice training.

*CHA Compensation* • \$8.50 per hour plus health insurance, sick/vacation days, commuter subsidy, retirement account.

*Number of CHA's* • 1.

*Methods Used to Recruit CHA's* • Advertising, word-of-mouth referral, referrals from community groups and professionals.

*Methods Used to Retain CHA's* • Pay increase.

*CHID Accession Number* • HE97P0744



241

**Program** • Rural Efforts Affecting Community Health (REACH):  
A Community-Based Health Advocate Program.

**Contact** • Gray, Jill.

**Agency** • Healthy Community Coalition, P.O. Box 29, Farmington, ME 04938.  
(207) 778-8185.

**Program Dates** • November 1996—continuing.

**Funding Source(s)** • State health department.

**Primary Purpose** • To improve education and access to health information by uninsured  
and underinsured men.

**Services Offered** • Education, prevention efforts, interventions.

**Geographic Area/Unit** • Rural communities in west central Maine.

**Program Setting** • Community-based agency.

**Target Population** • Uninsured and underinsured white adolescents and adults.

**CHA Title** • Health advocate.

**CHA Roles** • Plan/direct local health programs and activities, establish/maintain  
relationships with health professionals and community leaders.

**CHA Training** • Eight hours or less of initial training and less than 2 hours per month  
of inservice training.

**CHA Compensation** • Hourly wage plus sick/vacation days, educational leave, and expense  
reimbursement.

**Number of CHA's** • 2.

**Evaluation Plan** • Yes.

**CHID Accession Number** • HE97P1044.

## Health Promotion and Disease Prevention

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242

**Program** • Saint Anthony Free Medical Clinic.

**Contact** • Giancola, Elise.

**Agency** • Saint Anthony's Foundation, 121 Golden Gate Avenue, San Francisco, CA 94102. (415) 241-8320.

**Program Dates** • 1956–continuing.

**Delivery Sites** • Community, migrant centers/camps, public health clinics, hospitals/medical clinics.

**Funding Source(s)** • Private foundation.

**Primary Purpose** • To provide primary health care to uninsured San Francisco residents and those without access to health care.

**Materials Used** • Brochures, pamphlets, videos.

**Health Topic(s) Addressed** • Arthritis, breast and cervical cancer, diabetes, heart disease, high blood pressure, HIV/AIDS, injuries, nutrition, adolescent sexual behavior, tobacco use, stroke, substance abuse, incontinence, violence.

**Geographic Area/Unit** • Urban.

**Program Setting** • Religious institution, hospital/medical clinic, foundation.

**Target Population** • San Francisco residents who are uninsured or without access to health care.

**CHA Title** • Health interpreter/aide.

**CHA Roles** • Outreach, health promotion/education, risk assessment, client/community advocacy, patient treatment/services, social support/counseling.

**CHA Training** • No initial training; 2 hours per month of inservice training.

**CHA Compensation** • None.

**Number of CHA's** • 5.

*Number of Clients Served in 12 Months* • 15,000.

*Evaluation Plan* • Yes.

*Methods Used to Recruit CHA's* • Schools, personal contacts, advertising.

*Methods Used to Retain CHA's* • Continuing education, flexible schedule, positive working atmosphere.

*Methods Used to Retain Clients* • Establish positive client-staff relationships; provide thorough, high-quality services.

*CHID Accession Number* • HE96P0174.



## Health Promotion and Disease Prevention

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243

**Program** • Seacoast HealthNet.

**Contact** • White, Rebecca M.

**Agency** • Seacoast HealthNet, 212 North Haverhill Road, Exeter, NH 03833.  
(603) 772-8119.

**Program Dates** • August 1996–continuing.

**Delivery Sites** • Schools, homes, community centers, public health clinics.

**Funding Source(s)** • Federal agency, private foundations, local charitable organization.

**Primary Purpose** • To provide affordable health care to individuals and families with no or inadequate health insurance coverage and incomes within program guidelines.

**Services Offered** • CHAs provide family support, link community residents with community resources, refer residents to health care providers, and assist in case management.

**Materials Used** • Smoking cessation, asthma management, and stress management curricula; videos on attention deficit hyperactivity disorder, AIDS, unplanned pregnancy, and cancer; brochure; teaching aid; resource directory.

**Health Topic(s) Addressed** • Child health, family planning, HIV/AIDS, mental health, violence, arthritis, cholesterol screening/education, heart disease, immunizations, nutrition, physical activity, substance abuse, asthma, cancer, diabetes, high blood pressure, injuries, osteoporosis, adolescent sexual behavior, tobacco control.

**Geographic Area/Unit** • County.

**Program Setting** • Community-based agency.

**Target Population** • Low-income residents of the 21 counties in southeastern New Hampshire.

**CHA Title** • Community health advisor.

**CHA Roles** • Health promotion/education, case management, transportation.

## Health Promotion and Disease Prevention

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*CHA Training* • More than 40 hours of initial training and 2–4 hours per month of inservice training.

*CHA Compensation* • \$9.00 per hour plus health insurance and sick/vacation days.

*Number of CHA's* • 3.

*Evaluation Plan* • No.

*Methods Used to Recruit CHA's* • Advertising, referrals from other CHA's, word-of-mouth referral.

*Methods Used to Retain CHA's* • Program certificate, career advancement.

*CHID Accession Number* • HE97P0787.

## Health Promotion and Disease Prevention

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244

**Program** • SelfCare.

**Contact** • Brennan, Laura.

**Agency** • Neighborhood Health Clinics, Inc., 4945 Northeast 7th, Portland, OR 97211. (503) 288-5995.

**Program Dates** • Continuing.

**Delivery Sites** • Schools, religious organizations, homes, community centers.

**Funding Source(s)** • Local government agency, area health education centers, American Diabetes Association.

**Primary Purpose** • To teach self-care skills to uninsured individuals and families and create permanent self-care advocates in neighborhoods.

**Methods Employed** • Presentations at community organizations, one-on-one training.

**Materials Used** • Handbooks, first-aid kits, directories of low-cost health services.

**Health Topic(s) Addressed** • Diabetes, self-care.

**Geographic Area/Unit** • Urban, neighborhood.

**Program Setting** • Community-based agency.

**Target Population** • Neighborhood residents of all ages.

**CHA Title** • Community trainer, lay health promoter.

**CHA Roles** • Health promotion/education, social support/counseling, case management, community organizing.

**CHA Training** • 8 hours or less of initial training and 2–4 hours per month of inservice training.

**CHA Compensation** • No hourly wage; child care, commuter subsidy, and expense reimbursement.

**Number of CHA's** • 16.



*Evaluation Plan* • Yes.

*Methods Used to Recruit CHA's* • Referrals from other CHA's, word-of-mouth referral, referrals from community groups and professionals.

*Methods Used to Retain CHA's* • Program certificate.

*CHID Accession Number* • HP97P0751.

## Health Promotion and Disease Prevention

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245

**Program** • School-Centered Health Education and Services for Rural Communities.

**Contact** • Lara, Jesusa B.

**Agency** • College of Nursing and Health Sciences, University of Texas at El Paso, 1101 North Campbell, El Paso, TX 79902-0581.  
(915) 747-7223.

**Program Dates** • 1990–1993.

**Delivery Sites** • Schools, homes, community facilities, public health clinics.

**Funding Source(s)** • Private foundation.

**Primary Purpose** • To promote health-related careers, provide health education and health services to project communities, and contribute to effective strategies for meeting the health needs of Mexican Americans living in rural areas.

**Services Offered** • Information on health careers for elementary and middle-school students, health education classes, health services, training of volunteer community health workers.

**Materials Used** • Training manual in English and Spanish.

**Health Topic(s) Addressed** • Cancer, diabetes, family planning, heart disease, high blood pressure, HIV/AIDS, injuries, nutrition, pregnancy/prenatal care, physical activity, tobacco use, substance abuse, mental health, common childhood illnesses.

**Geographic Area/Unit** • Rural.

**Program Setting** • Community-based agency, school/school system.

**Target Population** • Mexican Americans in the rural communities of San Elizario, Montana Vista, and Canutillo.

**CHA Title** • Volunteer community health worker.

**CHA Roles** • Outreach, health promotion/education, client/community advocacy, patient treatment/services, social support/counseling.

*CHA Training* • 65 hours of initial training and 8–16 hours per month of inservice training.

*CHA Compensation* • None.

*Number of CHA's* • A total of 94 at the three project sites.

*Evaluation Plan* • Yes.

*Methods Used to Recruit CHA's* • Contacts with parent-teacher organizations, community meetings, client contacts.

*Methods Used to Retain CHA's* • Certificate of recognition and other incentives, continuing education, health services.

*Methods Used to Recruit Clients* • One-on-one recruitment by nurses/nursing students and CHA's.

*CHID Accession Number* • HE96P0167.



## Health Promotion and Disease Prevention

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246

**Program** • Temple Family Planning.

**Contact** • Scarborough, Ruth.

**Agency** • Temple University School of Medicine, 3425 North Carlisle Street, Philadelphia, PA 19140-5108. (215) 707-3061.

**Program Dates** • January 1969–continuing.

**Delivery Sites** • Schools, worksites, religious organizations, community centers, hospitals/private clinics.

**Funding Source(s)** • Federal agency, state government agency, patient fees.

**Primary Purpose** • To provide coordinated services to low-income women in North Philadelphia, especially preventive health care to adolescents.

**Services Offered** • Medical care, health education, training, workshops.

**Methods Employed** • Cooperates with local public schools to teach sex education and provides schools with staff support in teaching how bodies and minds develop and work; promotes an understanding of the reproductive system through training and workshops as a means to discourage premature and irresponsible sexual activity and prevent sexually transmitted diseases.

**Materials Used** • Brochures, training guide.

**Health Topic(s) Addressed** • Family planning, HIV/AIDS, pregnancy/prenatal care, nutrition, high blood pressure, osteoporosis, adolescent sexual behavior.

**Geographic Area/Unit** • Urban.

**Program Setting** • Hospital/medical clinic.

**Target Population** • Low-income girls and women aged 13 years and older.

**CHA Title** • Community health advisor.

**CHA Roles** • Health promotion/education, social support/counseling, risk identification.

*CHA Training* • More than 40 hours of initial training and 2–4 hours per month of inservice training.

*CHA Compensation* • \$13.00 per hour plus health insurance, sick/vacation days, tuition assistance, and pension plan.

*Number of CHA's* • 6.

*Evaluation Plan* • No.

*Methods Used to Recruit CHA's* • Advertising, referrals from community groups and professionals.

*CHID Accession Number* • HE97P0740.

247

**Program** • Tuberculosis Directly Observed Therapy (DOT).

**Contact** • Bray, Dawn.

**Agency** • St. Clare's Hospital, Spellman Center, 415 West 51st Street, Room 451, New York, NY 10019. (212) 459-8479.

**Program Dates** • August 1993–continuing.

**Delivery Sites** • Worksites, homes, hospitals/private clinics.

**Funding Source(s)** • Direct Medicaid billing.

**Primary Purpose** • To provide follow-up and supervision for persons with tuberculosis (TB) who are having difficulty adhering to their therapy regimen.

**Services Offered** • Assistance to patients in taking medications, contacts with patients' physicians.

**Materials Used** • Videos: "You Can Beat TB," "The Facts About TB," "TB and HIV: The Connection," and "Tuberculin Skin Testing"; brochures: *Directly Observed Therapy Can Help You Cure TB*; *TB/HIV: The Connection—What Health Care Workers Should Know*.

**Health Topic(s) Addressed** • HIV/AIDS, tuberculosis.

**Geographic Area/Unit** • Urban, multicounty.

**Program Setting** • Hospital/medical clinic/health maintenance organization.

**Target Population** • Adults with TB who belong to high-risk groups, including persons with drug-resistant TB, HIV infection, mental illness, or substance abuse problems and persons who are homeless, indigent, or new immigrants.

**CHA Title** • DOT (directly observed therapy) worker.

**CHA Roles** • Health promotion/education, social support/counseling, risk assessment, case management, community organizing, patient treatment/services.



- CHA Training* • 25–40 hours of initial training and 2–4 hours per month of inservice training.
- CHA Compensation* • No hourly wage; health insurance, sick/vacation days, tuition assistance, retirement account.
- Number of CHA's* • 2.
- Methods Used to Recruit CHA's* • Advertising, networking with other CHA programs.
- Methods Used to Retain CHA's* • Individual rewards at supervisor's discretion.
- Methods Used to Recruit Clients* • Physician referral.
- Methods Used to Retain Clients* • Incentives such as food coupons, transportation tokens, supportive case management services, and assistance with entitlement needs.
- CHID Accession Number* • HE97P0675.

## Health Promotion and Disease Prevention

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248

**Program** • West Virginia Community Health Promotion Program.

**Contact** • Vicario, Sally Shay.

**Agency** • West Virginia Bureau for Public Health, Division of Health Promotion, 1411 Virginia Street, East, Charleston, WV 25301. (304) 558-0644.

**Program Dates** • September 1991–continuing.

**Delivery Sites** • Public health clinics, medical schools.

**Funding Source(s)** • Centers for Disease Control and Prevention, state government agency.

**Primary Purpose** • To coordinate health promotion efforts throughout West Virginia and provide technical assistance as needed.

**Health Topic(s) Addressed** • HIV/AIDS, stroke, violence, cholesterol screening/education, heart disease, immunizations, nutrition, physical activity, substance abuse, cancer, diabetes, high blood pressure, injuries, tobacco use, community health.

**Geographic Area/Unit** • State.

**Target Population** • Residents of West Virginia.

**CHA Title** • Community health promotion specialist.

**CHA Roles** • Health promotion/education, community organizing.

**CHA Training** • More than 4 hours per month of inservice training.

**CHA Compensation** • Salaried through state contracts; salary and benefits depend on CHA's contract with host site.

**Number of CHA's** • 9.

**Methods Used to Recruit CHA's** • Advertising, networking with other CHA programs, referrals from community groups and professionals.

**CHID Accession Number** • HE97P0679.

## Maternal and Child Health

249

**Program** • **Best Start Program: Un Comienzo Mejor.**

**Contact** • Heiner, Thursa.

**Agency** • La Clinica del Valle, 95 Houston Road, Phoenix, OR 97520.  
(503) 776-9815.

**Program Dates** • September 1993—continuing.

**Delivery Sites** • Schools, homes, community facilities, migrant centers/camps, public health clinics, hospitals/medical clinics.

**Funding Source(s)** • Private foundation; contracts with county health department, state health agency, schools, and a hospital.

**Primary Purpose** • To provide perinatal care to Hispanic mothers.

**Services Offered** • Classes, support groups, home visits.

**Materials Used** • Videos, teaching aids, resource directory, brochures, posters, games.

**Health Topic(s) Addressed** • Family planning, nutrition, pregnancy/prenatal care, violence, child development, parenting skills, family communication.

**Program Setting** • Community-based agency, state health department, local health department, hospital/medical clinic, school/school system.

**Target Population** • Hispanic men, women, and children.

**CHA Title** • Promotora (lay health promoter).

**CHA Roles** • Outreach, health promotion/education, risk assessment, client/community advocacy, patient treatment/services, social support/counseling, transportation.

**CHA Training** • 80-360 hours of initial training and 8-30 hours per month of inservice training.

**CHA Compensation** • \$7.75 per hour plus health insurance, child care, medical support, retirement plan.

**Number of CHA's** • 6.



## Maternal and Child Health

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*Number of Clients Served in 12 Months* • 300.

*Evaluation Plan* • Yes.

*Methods Used to Recruit CHA's* • Advertising, word-of-mouth referral, services of unemployment office.

*Methods Used to Retain CHA's* • Continuing education, career advancement, pay increase, support and encouragement.

*Methods Used to Recruit Clients* • Professional approach, assurances of confidentiality.

*Methods Used to Retain Clients* • Frequent communication, ongoing support, client involvement in goal setting.

*CHID Accession Number* • HE96P0179.

250

**Program** • Breastfeeding Peer Counseling and Promotion Program.

**Contact** • Noris, Ana Maria.

**Agency** • The Family Place, 3309 16th Street, NW, Washington, DC 20010.  
(202) 265-0149.

**Program Dates** • 1991–continuing.

**Delivery Sites** • Agency offices, homes, hospitals.

**Funding Source(s)** • W.K. Kellogg Foundation.

**Primary Purpose** • To enhance bonding of mothers and their infants through successful breastfeeding and improve the health and development of infants born to low-income, inner-city mothers.

**Materials Used** • Resource directory, videos.

**Health Topic(s) Addressed** • Family planning, HIV/AIDS, nutrition, pregnancy/prenatal care.

**Geographic Area/Unit** • Urban.

**Program Setting** • Community-based agency.

**Target Population** • Low-income prospective parents and parents and their infants.

**CHA Title** • Breastfeeding peer counselor.

**CHA Roles** • Outreach, health promotion/education, client/community advocacy, social support/counseling.

**CHA Training** • One month of initial training and 1 continuing education training activity per month.

**CHA Compensation** • \$6.50 per hour plus compensatory time.

**Number of CHAs** • 4.

**Number of Clients  
Served in 12 Months** • 200.

**Evaluation Plan** • Yes.

## Maternal and Child Health

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*Methods Used to Recruit CHA's* • One-on-one contacts with program participants.

*Methods Used to Retain CHA's* • Pay increase, career advancement, flexible work schedule.

*Methods Used to Recruit Clients* • Word of mouth, referral from community groups.

*Methods Used to Retain Clients* • Assign a family worker to serve as a mentor and advocate, emphasize empowerment rather than welfare.

*CHID Accession Number* • HE96P0177.



251

**Program** • **Breastfeeding Peer Counselor Program.**

**Contact** • Pribble, Nancy.

**Agency** • Virginia Department of Health, Division of Chronic Disease Prevention/Nutrition, 1500 East Main Street, Room 132, Richmond, VA 23219. (804) 692-0681.

**Program Dates** • August 1989—continuing.

**Delivery Sites** • Schools, worksites, religious organizations, homes, community centers, public health clinics, hospitals/private clinics.

**Funding Source(s)** • Federal agency, state government agency, local government agency.

**Primary Purpose** • To increase the prevalence of breastfeeding among participants in the Special Supplemental Food Program for Women, Infants, and Children (WIC).

**Materials Used** • Peer counselor handbook, training manual.

**Health Topic(s) Addressed** • Child/infant health, family planning, HIV/AIDS, pregnancy/prenatal care, breastfeeding, immunizations, nutrition.

**Geographic Area/Unit** • State.

**Program Setting** • State health department, local health department, university/medical school.

**Target Population** • Adolescents and adults participating in WIC.

**CHA Title** • Peer counselor.

**CHA Roles** • Health promotion/education, social support/counseling, risk identification, patient treatment/services, transportation.

**CHA Training** • 9–24 hours of initial training and less than 2 hours per month of inservice training.

**CHA Compensation** • \$8.64 per hour in northern Virginia; \$7.06 per hour elsewhere in the state.

## Maternal and Child Health

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*Number of CHA's* • 99.

*Evaluation Plan* • Yes.

*Methods Used to Recruit CHA's* • Advertising, referrals from other CHA's, word-of-mouth referral, referrals from community groups and professionals.

*Methods Used to Retain CHA's* • Graduation ceremony, program certificate.

*CHID Accession Number* • HE97P0497.

252

**Program** • Homeless Prenatal Program.

**Contact** • Ryan, Martha; Woodruff-Benson, Ramona.

**Agency** • Homeless Prenatal Program, 995 Market Street, Suite 1010, San Francisco, CA 94103. (415) 546-6756.

**Program Dates** • November 1989–continuing.

**Delivery Sites** • Churches, homes, community facilities, public health clinics, hospitals/medical clinics, homeless shelters, agency offices.

**Funding Source(s)** • Private foundation, individual donors, fundraising activities.

**Primary Purpose** • To improve access to prenatal care for homeless women.

**Services Offered** • Peer counseling, peer support groups, medical assessment/referral, substance abuse counseling/referral, housing assistance, income/benefits advocacy.

**Health Topic(s) Addressed** • Family planning, HIV/AIDS, nutrition, pregnancy/prenatal care, adolescent sexual behavior, substance abuse, violence.

**Geographic Area/Unit** • Urban.

**Program Setting** • Community-based agency.

**Target Population** • Homeless women.

**CHA Title** • Community health worker.

**CHA Roles** • Outreach, health promotion/education, risk assessment, client/community advocacy, patient services, social support/counseling, transportation.

**CHA Training** • Initial training consisting of an intensive one-on-one session and weekly inservice training on health and social service topics.

**CHA Compensation** • \$600 monthly stipend plus bus pass.

**Number of CHA's** • 9.



## Maternal and Child Health

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*Number of Clients Served in 12 Months* • 380 families.

*Evaluation Plan* • Yes.

*Methods Used to Recruit CHA's* • Close observation of clients to select those who would be effective CHAs.

*Methods Used to Retain CHA's* • Program goal is full-time employment of CHA's in their field of choice.

*Methods Used to Recruit Clients* • Outreach by CHA's, referrals by former clients and other nonprofit organizations.

*Methods Used to Retain Clients* • Peer support, nonjudgmental approach, focus on client-identified needs.

*CHID Accession Number* • HE96P0954.

253

**Program** • Iowa Healthy Families Resource Mothers Program.

**Contact** • Sadden, Fran.

**Agency** • Siouxland District Health Department, 205 5th Street, Sioux City, IA 51101. (712) 279-6119.

**Program Dates** • July 1992–continuing.

**Delivery Sites** • Homes.

**Funding Source(s)** • State agency.

**Primary Purpose** • To prevent infant mortality.

**Services Offered** • Home visits.

**Materials Used** • Curriculum, brochure, resource directory.

**Health Topic(s) Addressed** • Family planning, HIV/AIDS, pregnancy/prenatal care, adolescent sexual behavior, violence.

**Program Setting** • Local health department.

**Target Population** • Women of childbearing age and their infants.

**CHA Title** • Resource mother.

**CHA Roles** • Outreach, health promotion/education, risk assessment, client advocacy, social support/counseling.

**CHA Training** • 40 hours of initial training and 6 hours per month of inservice training.

**CHA Compensation** • \$18.14 per hour.

**Number of CHAs** • 4.

**Number of Clients Served in 12 Months** • 120.

**Evaluation Plan** • Yes.

## Maternal and Child Health

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*Methods Used to Recruit Clients* • Networking with other agencies.

*Methods Used to Retain Clients* • Provide support system and high-quality services.

*CHID Accession Number* • HE96P0180.



254

**Program** • MotherNet L.A.

**Contact** • Henning, Maryjane.

**Agency** • INMED (International Services for Medicine), 1316 West Rosecrans, Compton, CA 90222. (310) 632-3353.

**Program Dates** • January 1995–continuing.

**Delivery Sites** • Homes, community centers, hospitals/private clinics.

**Funding Source(s)** • Private corporation, private foundation.

**Primary Purpose** • To address the specific needs of disadvantaged pregnant women and teens, new mothers, and their families, especially blacks and Hispanics.

**Services Offered** • Home visits, resource center.

**Materials Used** • MotherNet America curriculum, training guide, and handouts; videos; resource directories.

**Health Topic(s) Addressed** • Child health, family planning, HIV/AIDS, mental health, pregnancy/prenatal care, violence, immunizations, nutrition, physical activity, adolescent sexual behavior, tobacco use.

**Geographic Area/Unit** • City and vicinity.

**Program Setting** • Community-based agency, international nonprofit group.

**Target Population** • Disadvantaged pregnant women and teens, new mothers, and their families, especially blacks and Hispanics, in Los Angeles County, California.

**CHA Title** • Home visitor or resource mother.

**CHA Roles** • Health promotion/education, social support/counseling, risk identification, case management, transportation.

**CHA Training** • 25–40 hours of initial training and more than 4 hours per month of inservice training.

## Maternal and Child Health

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*CHA Compensation* • Monthly stipend plus commuter subsidy.

*Number of CHA's* • 4.

*Evaluation Plan* • Yes.

*Methods Used to Recruit CHA's* • Advertising, word-of-mouth referral.

*Methods Used to Retain CHA's* • Graduation ceremony, pay increase, program certificate, career advancement.

*CHID Accession Number* • HE97P0498.

255

**Program** • MotherNet Loudoun.

**Contact** • Calley, Susana.

**Agency** • INMED (International Services for Medicine)/MotherNet America,  
45449 Severn Way, Suite 161, Sterling, VA 20166.  
(703) 444-4477.

**Program Dates** • October 1994—continuing.

**Delivery Sites** • Schools, homes, public health clinics.

**Funding Source(s)** • Private foundations.

**Primary Purpose** • To provide friendly support, information, and assistance to  
disadvantaged pregnant women and new mothers residing in Loudoun  
County, Virginia.

**Services Offered** • Education, advice, support group, referral to medical and social  
services.

**Materials Used** • MotherNet America curriculum and training guide, brochures on  
program services.

**Health Topic(s) Addressed** • Family planning, pregnancy/prenatal care, immunizations, nutrition.

**Geographic Area/Unit** • County.

**Program Setting** • Community-based agency.

**Target Population** • Disadvantaged women of childbearing age residing in Loudoun  
County, Virginia.

**CHA Title** • Resource mother.

**CHA Roles** • Health promotion/education, social support/counseling, case  
management, transportation.

**CHA Training** • 25–40 hours of initial training and 2–4 hours per month of inservice  
training.

**CHA Compensation** • \$7.70 per hour plus mileage.



## Maternal and Child Health

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*Number of CHA's* • 3 staff, 15 volunteers.

*Evaluation Plan* • Yes.

*Methods Used to Recruit CHA's* • Advertising, referrals from other CHA's, word-of-mouth referral.

*Methods Used to Retain CHA's* • Graduation ceremony, program certificate, small gifts donated by local businesses.

*CHID Accession Number* • HE97P0682.

256

**Program** • Opening Doors.

**Contact** • Fleischman, Catherine.

**Agency** • Healthy Start, Inc., 19945 Southwest Boones Ferry Road, Tualatin, OR 97062. (503) 691-8552.

**Program Dates** • January 1995–continuing.

**Delivery Sites** • Homes, community centers, hospitals/private clinics, program offices.

**Funding Source(s)** • Local government agency, private foundations, managed care plans.

**Primary Purpose** • To address and improve birth outcomes for at-risk women residing in Washington County, Oregon, through the collaborative efforts of key local health care players.

**Services Offered** • Case finding and outreach, education about the Oregon Health Plan and managed care systems, assistance with eligibility determination and application for the Oregon Health Plan, prenatal care throughout pregnancy, referrals to other social service organizations.

**Methods Employed** • (1) Seeks out low-income pregnant women at risk of not receiving prenatal care; motivates them to seek care; and provides the needed information, referral, and advocacy to enable them to do so.  
(2) Assists providers and insurers to better understand the unique circumstances of low-income families that can intervene with early entry into care and compliance.

**Health Topic(s) Addressed** • Family planning, pregnancy/prenatal care.

**Geographic Area/Unit** • County.

**Program Setting** • Community-based agency.

**Target Population** • Low-income women in Washington County, Oregon.

**CHA Title** • Lay health outreach worker.

**CHA Roles** • Social support/counseling, risk identification, case management, community organizing.

## Maternal and Child Health

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**CHA Training** • 25–40 hours of initial training and 2–4 hours per month of inservice training.

**CHA Compensation** • \$600 per month (VISTA) living allowance plus health insurance, sick/vacation days, and tuition assistance.

**Number of CHA's** • 7 (VISTA volunteers).

**Evaluation Plan** • Yes.

**Methods Used to Recruit CHA's** • Advertising, referrals from other CHA's, word-of-mouth referral, networking with other CHA programs, referrals from community groups and professionals, VISTA program.

**Methods Used to Retain CHA's** • Program certificate, career advancement.

**CHID Accession Number** • HE97P1002.

257

**Program** • Perinatal Projects of Cuyahoga County.

**Contact** • Rottman, Carol J.

**Agency** • First Draft Consulting, 28500 Gates Mills Boulevard, Cleveland, OH 44124. (216) 831-9295.

**Program Dates** • August 1987–August 1992.

**Delivery Sites** • Community locations, public health clinics.

**Funding Source(s)** • Private foundation.

**Primary Purpose** • To reduce infant mortality and morbidity by linking pregnant women who have not accessed medical care to comprehensive prenatal care.

**Services Offered** • Help with first prenatal visit, support in accessing preventive health care, telephone hotline.

**Materials Used** • Paper on community empowerment, booklet on prenatal care, training guide.

**Health Topic(s) Addressed** • Family planning, pregnancy/prenatal care, community-based outreach.

**Geographic Area/Unit** • Urban.

**Program Setting** • Hospital/medical clinic.

**Target Population** • Pregnant women.

**CHA Title** • Outreach worker.

**CHA Roles** • Outreach, health promotion/education, client/community advocacy, social support/counseling.

**CHA Training** • 12 weeks of initial training.

**CHA Compensation** • \$6.00 per hour plus a bonus depending on the type of client service provided.

**Number of CHA's** • 60.



## Maternal and Child Health

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*Evaluation Plan* • Yes.

*Methods Used to Recruit CHA's* • Person-to-person contacts in the target community, fliers at strategic locations, recruitment of current clients.

*Methods Used to Retain CHA's* • Bonus system for meeting goals, career advancement.

*Methods Used to Recruit Clients* • Person-to-person contacts in the target community, policy of hiring as CHA's only persons from the community, CHA interest/responsiveness.

*Methods Used to Retain Clients* • Persuasive, caring attitude and strong support of CHA's.

*CHID Accession Number* • HE96P0178.

258

**Program** • Prenatal Education Program.

**Contact** • Mason, Robert.

**Agency** • Mercy Mobile Health Care, 60 11th Street, Atlanta, GA 30309.  
(404) 249-8141.

**Program Dates** • January 1991–continuing.

**Delivery Sites** • Homes, community facilities, public health clinics.

**Funding Source(s)** • Federal agency, March of Dimes.

**Primary Purpose** • To increase the number of healthy births among Hispanic women through prenatal education.

**Services Offered** • Courses on fetal development and basic health care for pregnant women and on labor and delivery, care of the newborn, breastfeeding, car safety, and family planning.

**Health Topic(s) Addressed** • Family planning, pregnancy/prenatal care.

**Geographic Area/Unit** • Urban.

**Program Setting** • Community-based agency, religious institution, hospital/medical clinic.

**Target Population** • Hispanic women of childbearing age and their spouses/partners.

**CHA Title** • Resource mother, health promoter.

**CHA Roles** • Outreach, health promotion/education, risk assessment, client/community advocacy, social support/counseling.

**CHA Training** • 55 hours of initial training and 2 hours per month of inservice training.

**CHA Compensation** • \$8.00 per hour plus a stipend of \$15 per week, health insurance, tuition reimbursement, and compensatory time.

**Number of CHA's** • 5.

**Evaluation Plan** • Yes.

## Maternal and Child Health

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*Methods Used to Recruit CHA's* • Networking with community-based organizations, word of mouth, program graduates.

*Methods Used to Retain CHA's* • Educational opportunities, health benefits.

*Methods Used to Recruit Clients* • Outreach and publicity, networking with other agencies.

*Methods Used to Retain Clients* • Support services, dedication of CHA's.

*CHID Accession Number* • HE96P0958.

259

**Program** • **Prevention Outreach: Parent to Parent Program.**

**Contact** • Lindsay, Judy.

**Agency** • Butterworth Hospital, 100 Michigan, Northeast, MC94, Grand Rapids, MI 49503. (616) 391-2627.

**Program Dates** • July 1990–continuing.

**Delivery Sites** • Homes, community centers, hospitals/private clinics.

**Funding Source(s)** • Federal agency, state government agency, local government agency, private foundations.

**Primary Purpose** • To improve the health of pregnant women, infants, children, and families.

**Materials Used** • Various training materials are used during the 7-week course that all CHA's attend.

**Health Topic(s) Addressed** • Pregnancy/prenatal care, infant and child development.

**Geographic Area/Unit** • Urban, neighborhood.

**Program Setting** • Community-based agency, hospital.

**Target Population** • Men, women, children, and adolescents.

**CHA Title** • Community health advocate.

**CHA Roles** • Health promotion/education, risk identification.

**CHA Training** • More than 40 hours of initial training and more than 4 hours per month of inservice training.

**CHA Compensation** • Entry level compensation is \$8.41 per hour; full-time CHA's receive dental/health and life insurance, sick/vacation days, tuition assistance, and a retirement account.

**Number of CHA's** • 13.

**Evaluation Plan** • Yes.



## Maternal and Child Health

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*Methods Used to Recruit CHA's* • Referrals from other CHA's, word-of-mouth referral, networking with other CHA programs, referrals from community groups and professionals.

*Methods Used to Retain CHA's* • Pay increase, program certificate, career advancement.

*CHID Accession Number* • HE97P0672.

## Nutrition

260

**Program** • Consumer and Family Service.

**Contact** • Benavente, Janet C.

**Agency** • University of Guam Cooperative Extension, College of Agriculture and Life Sciences, 303 University Drive, UOG Station, Mangilao, Guam 96923. (671) 735-2026.

**Program Dates** • September 1993–continuing.

**Delivery Sites** • Schools, religious organizations, homes, community centers, public health clinics.

**Funding Source(s)** • Federal agency, state government agency, local government agency.

**Primary Purpose** • To provide education on nutrition and food safety to residents of Guam.

**Materials Used** • Curriculum and video on breastfeeding, teaching aids on fiber and fat, brochures on nutrition, video and brochure on food safety.

**Health Topic(s) Addressed** • Child health, HIV/AIDS, pregnancy/prenatal care, violence, cholesterol screening/education, heart disease, nutrition, diabetes.

**Geographic Area/Unit** • Guam.

**Program Setting** • Schools, university medical school.

**Target Population** • Residents of Guam.

**CHA Title** • Community health advisor.

**CHA Roles** • Health promotion/education.

**CHA Training** • More than 40 hours of initial training and 2–4 hours per month of inservice training.

**CHA Compensation** • \$10.00 per hour plus health insurance, sick/vacation days, and retirement account.

**Number of CHA's** • 6.

## Nutrition

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*Methods Used to Recruit CHA's* • Word-of-mouth referral, referrals from community groups and professionals.

*Methods Used to Retain CHA's* • Pay increase, program certificate, career advancement.

*CHID Accession Number* • HE97P0788.

261

**Program** • **5 A Day: Healthier Eating for the Overlooked Worker.**

**Contact** • Buller, Mary Klein.

**Agency** • University of Arizona, Arizona Cancer Center, Behavioral Sciences Program, 2302 East Speedway Boulevard, Suite 202, Tucson, AZ 85719. (520) 318-7100.

**Program Dates** • May 1993–November 1997.

**Delivery Sites** • Worksites.

**Funding Source(s)** • Federal agency.

**Primary Purpose** • To increase the consumption of fruits and vegetables among the target population, using the worksite as the channel for access.

**Methods Employed** • Program kit for each employer's wellness coordinator, campaign plan and materials, cafeteria promotions, speakers bureau.

**Materials Used** • Health peer training manual, 5 a day guidebook and newsletter, cookbooks.

**Health Topic(s) Addressed** • Heart disease, nutrition, cancer prevention.

**Geographic Area/Unit** • Urban, multicounty.

**Program Setting** • University/medical school.

**Target Population** • The largely Hispanic population of adults aged 20–64 years who are employed in low-paying public-sector jobs that do not require high levels of education or English literacy.

**CHA Title** • Health peer.

**CHA Roles** • Health promotion/education, social support/counseling.

**CHA Training** • 9–24 hours of initial training.

**CHA Compensation** • \$11.25 per hour.

**Number of CHA's** • 43.



## Nutrition

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*Evaluation Plan* • Yes.

*Methods Used to Recruit CHA's* • Network analysis.

*Methods Used to Retain CHA's* • Graduation ceremony, program certificate, articles in employee newsletter.

*CHID Accession Number* • HE97P0884.

## Quality of Life

262

**Program** • Elder Network.

**Contact** • Doucette, Mary.

**Agency** • Elder Network, Assisi Heights, Box 4900, Rochester, MN 55903.  
(507) 285-5272.

**Program Dates** • September 1988–continuing.

**Delivery Sites** • Religious organizations, community sites, public health clinics,  
retirement centers.

**Funding Source(s)** • Federal agency, local government agency.

**Primary Purpose** • To provide mental health support services to older adults using peer  
volunteers.

**Services Offered** • Peer counseling, peer education.

**Materials Used** • Brochures, trainer and trainee manuals on options for growth, video  
on seniors and alcohol abuse, community assessment survey.

**Health Topic(s) Addressed** • Nutrition, physical activity, substance abuse, mental health issues  
related to aging.

**Geographic Area/Unit** • Rural, multicounty.

**Program Setting** • Private, nonprofit agency.

**Target Population** • Adults aged 55 years and older living in southeast Minnesota.

**CHA Title** • Peer counselor or peer educator.

**CHA Roles** • Outreach, health promotion/education, client advocacy, social  
support/counseling.

**CHA Training** • 42 hours of initial training and 2–3 hours per month of case review  
supervision.

**CHA Compensation** • Mileage reimbursement only.

**Number of CHA's** • 70.

## Quality of Life

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*Evaluation Plan* • Yes.

*Methods Used to Recruit CHA's* • Recruited from current program participant pool.

*Methods Used to Retain CHA's* • Investment in initial training, ongoing supervision and inservice education, group interaction and support.

*Methods Used to Recruit Clients* • Professional referrals, inserts in public utilities billing to entire community.

*Methods Used to Retain Clients* • Provision of consistent services, establishment of good relationships.

*CHID Accession Number* • HE94P1518.

263

**Program** • Senior Health Peers for Rural Health Promotion.

**Contact** • Sennott-Miller, Lee.

**Agency** • University of Arizona College of Nursing, 1305 North Martin, Room 415, P.O. Box 210203, Tucson, AZ 85721-0203.  
(520) 626-2705.

**Program Dates** • September 1994–August 1997.

**Delivery Sites** • Homes.

**Funding Source(s)** • Federal agency.

**Primary Purpose** • To (1) test the effectiveness of a peer counseling model in improving self-care knowledge and behavior among Hispanic and white elderly persons living in a rural community, (2) to determine the level of contact needed to observe changes in knowledge and behavior, (3) to identify differences between white and Hispanic elderly persons in responding to contact by peer counselors, and (4) to describe the information-sharing patterns of white and Hispanic peer counselors.

**Methods Employed** • Pre-post test with intervention to determine the effectiveness of health peers in increasing knowledge of general health promotion and activities to reduce risk.

**Materials Used** • Curriculum, teaching manual and handouts, resource directory.

**Health Topic(s) Addressed** • Arthritis, heart disease, nutrition, physical activity, diabetes, osteoporosis, stress reduction, medication management, chronic illness management, normal aging.

**Geographic Area/Unit** • Rural town and vicinity.

**Program Setting** • University college of nursing.

**Target Population** • Persons aged 60 years and older in the study community.

**CHA Title** • Health peer.

**CHA Roles** • Health promotion/counseling, social support/counseling, risk identification.



## Quality of Life

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*CHA Training* • 9–24 hours of initial training and more than 4 hours per month of inservice training.

*CHA Compensation* • \$8.33 per hour plus commuter subsidy.

*Number of CHA's* • 7.

*Evaluation Plan* • Yes.

*Methods Used to Recruit CHA's* • Advertising, referrals from other CHA's, word-of-mouth referral, referrals from community groups and professionals.

*Methods Used to Retain CHA's* • Graduation ceremony, program certificate.

*CHID Accession Number* • HE97P0742.

## Sexual Behavior

264

**Program** • Evanston Health Department Community Health Services.

**Contact** • Figueroa, Allen A.

**Agency** • Evanston Health Department, 2100 Ridge Avenue, Evanston, IL 60201. (847) 866-2952.

**Program Dates** • Continuing.

**Delivery Sites** • Schools, worksites, public health clinics.

**Funding Source(s)** • Federal agency, state government agency, local government agency.

**Primary Purpose** • To provide health care services to Evanston residents.

**Services Offered** • HIV testing program, family planning program, dental clinic, sexually transmitted disease clinic.

**Health Topic(s) Addressed** • Child health, family planning, HIV/AIDS, pregnancy/prenatal care, violence, cholesterol screening/education, immunizations, nutrition, diabetes, high blood pressure, adolescent sexual behavior, tobacco use.

**Geographic Area/Unit** • City and vicinity.

**Program Setting** • Local health department, schools.

**Target Population** • Evanston residents.

**CHA Title** • Community health advisor.

**CHA Roles** • Health promotion/education, risk identification, patient treatment/ services.

**CHA Training** • 8 hours or less of initial training and less than 2 hours per month of inservice training.

**CHA Compensation** • Hourly wage plus health insurance, sick/vacation days, tuition assistance, pension plan, and retirement account.

**Number of CHA's** • 3.

## Sexual Behavior

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*Evaluation Plan* • No.

*Methods Used to* • Pay increase.  
*Retain CHA's*

*CHID Accession Number* • HE97P0789.

265

**Program** • HIV/AIDS Education.

**Contact** • Mason, Robert.

**Agency** • Mercy Mobile Health Care, 60 11th Street, Atlanta, GA 30309.  
(404) 249-8141.

**Program Dates** • September 1989–continuing.

**Delivery Sites** • Schools, worksites, religious organizations, homes, community sites, migrant centers/camps, public health clinics, medical clinics, shelters, correctional institutions.

**Funding Source(s)** • Georgia Department of Human Resources, Centers for Disease Control and Prevention.

**Primary Purpose** • To provide education about HIV/AIDS and other sexually transmitted diseases (STD's) to homeless and indigent persons aged 13–64 years.

**Services Offered** • Education on HIV/AIDS and other STD's, HIV testing, screening for tuberculosis.

**Methods Employed** • Lectures, group discussions.

**Materials Used** • Videos on HIV/AIDS, board games, slides on STD's, penile model.

**Health Topic(s) Addressed** • HIV/AIDS and other STD's, tuberculosis.

**Geographic Area/Unit** • Multicounty.

**Program Setting** • Community-based agency, religious institution, hospital/medical clinic, nonprofit.

**Target Population** • Homeless and indigent adolescents and adults.

**CHA Title** • Outreach worker or resource specialist.

**CHA Roles** • Outreach, health promotion/education, risk assessment, client/community advocacy, social support/counseling, transportation.

**CHA Training** • 40 hours of initial training and 2 hours per month of inservice training.



## Sexual Behavior

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**CHA Compensation** • \$9–\$10 per hour plus health insurance, tuition reimbursement, and compensatory time.

**Number of CHA's** • 6.

**Number of Clients Served in 12 Months** • 40,000 encounters.

**Evaluation Plan** • Yes.

**Methods Used to Recruit CHA's** • Networking with other community-based organizations, word-of-mouth referral.

**Methods Used to Retain CHA's** • Health benefits, continuing education, career advancement.

**Methods Used to Recruit Clients** • Outreach, networking with other organizations, advertising/marketing.

**Methods Used to Retain Clients** • Support services, dedication and persistence of CHA's.

**CHID Accession Number** • HE96P0959.

266

**Program** • HRS D-3 AIDS Program.

**Contact** • Koehler-Sides, Gay.

**Agency** • Department of Health and Rehabilitative Services, 1000 Northeast 16th Avenue, Box 19, Gainesville, FL 32601. (904) 336-7197.

**Program Dates** • January 1989–continuing.

**Delivery Sites** • Community sites, public health clinics.

**Funding Source(s)** • State government agency.

**Primary Purpose** • To slow the spread of HIV/AIDS.

**Services Offered** • Education, condom distribution, counseling, HIV testing, referrals.

**Methods Employed** • Street outreach, coordination with the Salvation Army and a local women's clinic.

**Materials Used** • Brochures: *You and AIDS: Be Safe, You Don't Have to Be White or Gay to Get AIDS*; videos.

**Health Topic(s) Addressed** • HIV/AIDS, sexual behavior.

**Geographic Area/Unit** • County.

**Program Setting** • Local health department.

**Target Population** • Low-income and homeless adolescents and adults.

**CHA Title** • AIDS outreach worker.

**CHA Roles** • Outreach, health promotion/education, social support/counseling.

**CHA Training** • 20 hours of initial training and 2 hours per month of inservice training.

**CHA Compensation** • \$7.00 per hour.

**Number of CHA's** • 2.

## Sexual Behavior

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*Number of Clients Served in 12 Months* • 3,000.

*Evaluation Plan* • No.

*Methods Used to Recruit CHA's* • Advertising, word-of-mouth in target community.

*Methods Used to Retain CHA's* • Careful screening during hiring process.

*CHID Accession Number* • HE94P1527.

267

**Program** • Peer Health Education Program.

**Contact** • Laing, Jessyca.

**Agency** • San Diego State University, Student Health Services, 5500 Campanile Drive, San Diego, CA 92182-4701. (619) 594-4133.

**Program Dates** • Continuing.

**Delivery Sites** • Colleges/universities.

**Funding Source(s)** • Student health service fees.

**Primary Purpose** • To increase college students' awareness of health issues and decrease health risk factors.

**Methods Employed** • Lectures, discussion activities, role playing.

**Materials Used** • Peer health education manual; training manual for peer sexuality educators and peer opinion leaders; brochures on HIV/AIDS, date rape, and contraception.

**Health Topic(s) Addressed** • Sexual behavior and contraception, HIV/AIDS, date rape, alcohol use.

**Geographic Area/Unit** • College campus.

**Program Setting** • University.

**Target Population** • College/university students.

**CHA Title** • Peer sexuality educator or peer opinion leader.

**CHA Roles** • Health promotion/education.

**CHA Training** • 1 semester of initial training and 4 hours per month of inservice training.

**CHA Compensation** • Academic credit.

**Number of CHA's** • 25.



## Sexual Behavior

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*Number of Clients Served in 12 Months* • 3,000.

*Evaluation Plan* • Yes.

*Methods Used to Recruit CHA's* • Referral from other CHAs; advertising/marketing efforts, including distributing flyers during freshman orientation.

*Methods Used to Retain CHA's* • Building team approaches, providing positive feedback, holding regular meetings to discuss problems/strategies.

*Methods Used to Recruit Clients* • Faculty referral.

*CHID Accession Number* • HE96P0173.

268

**Program** • **Respect and Protect.****Contact** • Robinson, Jadis.**Agency** • University of North Carolina, Sexually Transmitted Epidemic Prevention Project, Department of Epidemiology, CB 7400, Chapel Hill, NC 27599. (919) 291-3300.**Program Dates** • Continuing.**Delivery Sites** • Schools, worksites, religious organizations, homes, community centers.**Funding Source(s)** • Federal agency, state government agency.**Primary Purpose** • To prevent sexually transmitted diseases among black women.**Materials Used** • Training guide.**Health Topic(s) Addressed** • Sexually transmitted diseases.**Geographic Area/Unit** • Rural, county.**Program Setting** • Community-based agency, local health department, university.**Target Population** • Black women aged 20–64 years.**CHA Title** • Community health advisor.**CHA Roles** • Health promotion/education, social support/counseling, community organizing, transportation.**CHA Training** • 9–24 hours of initial training and 2–4 hours per month of inservice training.**CHA Compensation** • None.**Evaluation Plan** • Yes.**Methods Used to Recruit CHA's** • Referrals from other CHA's, word-of-mouth referral.

## Sexual Behavior

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*Methods Used to Retain CHA's* • Graduation ceremony, program certificate.

*CHID Accession Number* • HE97P0752.

## Substance Abuse

269

**Program** • Berks Parents Services Collaborative.

**Contact** • Weeks, Shelby M.

**Agency** • The Children's Home of Reading, 1010 Centre Avenue, Reading, PA 19601. (610) 478-9830.

**Program Dates** • September 1992–continuing.

**Delivery Sites** • Homes, community centers, public health clinics, domestic violence shelters.

**Funding Source(s)** • State government agency.

**Primary Purpose** • To improve the quality of life of substance-abusing pregnant and postpartum women and their infants by linking them to local drug-abuse treatment and medical and social services.

**Services Offered** • Intensive case management and outreach.

**Materials Used** • Curricula on drug abuse and stress management, videos, resource directory, training guide.

**Health Topic(s) Addressed** • Child health, family planning, HIV/AIDS, mental health, pregnancy/prenatal care, immunizations, nutrition, substance abuse.

**Geographic Area/Unit** • County.

**Program Setting** • Community-based agency.

**Target Population** • Substance-abusing pregnant and postpartum women residing in Berks County, Pennsylvania, and their infants.

**CHA Title** • Neighborhood outreach worker.

**CHA Roles** • Health promotion/education, social support/counseling, risk identification, transportation.

**CHA Training** • 25–40 hours of initial training and 5 hours per month of inservice training.



## Substance Abuse

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*CHA Compensation* • \$8.17 per hour plus health insurance, sick/vacation days, tuition assistance, and pension plan.

*Number of CHA's* • 3.

*Evaluation Plan* • Yes.

*Methods Used to Recruit CHA's* • Advertising, word-of-mouth referral.

*Methods Used to Retain CHA's* • Pay increase, career advancement.

*CHID Accession Number* • HE97P0683.

270

**Program** • Los Pasos Program.

**Contact** • Riordan, Mary.

**Agency** • University of New Mexico, SOM-Los Pasos Program, Pediatric Department, ACC3-W, Albuquerque, NM 87131-5311. (505) 272-6843.

**Program Dates** • May 1990–continuing.

**Delivery Sites** • Schools, homes, community facilities, hospitals/medical clinics, Headstart offices.

**Funding Source(s)** • Federal agency, state government agency.

**Primary Purpose** • To coordinate services for drug-exposed infants and their families; to identify, support, and educate families so they can recognize and respond to the needs of their children.

**Services Offered** • Training for parents, medical staff, and others in reading infant cues, positioning and handling babies, and infant massage to enhance parent-infant bonding; regular assessment of infants to ensure early detection and treatment of problems.

**Methods Employed** • Videotape teaching sessions to provide parents with instructional tools and a record of their child's growth.

**Materials Used** • Program brochure.

**Health Topic(s) Addressed** • Family planning, HIV/AIDS, nutrition, adolescent sexual behavior, substance abuse, violence, well-baby care.

**Geographic Area/Unit** • Urban, multicounty.

**Program Setting** • Hospital/medical clinic.

**Target Population** • At-risk infants and their families.

**CHA Title** • Family liaison or family advocate.

**CHA Roles** • Outreach, health promotion/education, risk assessment, client/community advocacy, social support/counseling, transportation.

## Substance Abuse

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*CHA Training* • 10 hours per month of inservice training.

*CHA Compensation* • \$8.00 per hour plus mileage reimbursement.

*Number of CHA's* • 2.

*Number of Clients  
Served in 12 Months* • 100.

*Evaluation Plan* • No.

*Methods Used to  
Recruit CHA's* • Recruit from training events.

*Methods Used to  
Retain CHA's* • Offering competitive compensation, providing professional treatment and respect.

*CHID Accession Number* • HE96P0955.

## Tobacco Control

271

**Program** • Tobacco Control Resource Center.

**Contact** • St. Cook, Carol.

**Agency** • San Diego County Department of Health Services, Division of Public Health Education, P.O. Box 85222, Mail Stop P-511E, San Diego, CA 92186-5222. (619) 236-2705.

**Program Dates** • January 1994–June 1996.

**Funding Source(s)** • Local government.

**Primary Purpose** • To provide health education and health promotion in San Diego County.

**Services Offered** • Prevention education, cessation resources.

**Materials Used** • Leader's guides: *The Next Step: Tobacco Education Program for People in Recovery*, *Stay Clear of the Tobacco Trap*, and *Healthy Choices/Healthy Beginnings*; self-help guide: *The Next Step: Stop-Smoking Guide for People in Recovery*.

**Health Topic(s) Addressed** • Tobacco use.

**Geographic Area/Unit** • County.

**Program Setting** • Local health department.

**Target Population** • Current smokers in recovery from alcohol and other drugs, at-risk youth, women at risk for little or no prenatal care, employees at worksites.

**CHA Title** • Community representative.

**CHA Roles** • Health promotion/education.

**CHA Training** • 20 hours of initial training and 5 hours per month of inservice training.

**CHA Compensation** • \$10.00 per hour plus \$27.50 per presentation.



## **Tobacco Control**

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*Number of CHA's* • 29.

*Number of Clients  
Served in 12 Months* • 7,800.

*Evaluation Plan* • Yes.

*CHID Accession Number* • HE96P0172.

272

**Program** • Youth Tobacco Prevention Program.

**Contact** • Hargrove-Roberson, Diane.

**Agency** • Louisiana Office of Public Health, P.O. Box 60630, R414,  
New Orleans, Louisiana 70160. (504) 568-7210.

**Program Dates** • Fall 1995–continuing.

**Delivery Sites** • Schools.

**Funding Source(s)** • State agency.

**Primary Purpose** • To control and prevent tobacco use among children and adolescents in New Orleans, Louisiana, by supporting their self-directed efforts.

**Methods Employed** • Each school has a community team comprised of the school principal, a public health nurse, a fifth-grade and a sixth-grade teacher, and students.

**Health Topic(s) Addressed** • Tobacco use.

**Geographic Area/Unit** • City.

**Program Setting** • Schools.

**Target Population** • Fifth and sixth graders.

**CHA Title** • Community health worker.

**CHA Roles** • Health promotion/education.

**CHA Training** • 8 hours or less of initial training and inservice training at an annual conference.

**CHA Compensation** • None.

**Number of CHA's** • 102.

**CHID Accession Number** • HE97P0620.



## Training Programs

273

**Program** • Atlanta Interfaith Health Program.

**Contact** • Droege, Tom.

**Agency** • Interfaith Health Program, The Carter Center, One Copenhill,  
453 Freedom Parkway, Atlanta, GA 30307.  
(404) 420-3846.

**Program Dates** • January 1994–December 1996.

**Delivery Sites** • Religious organizations.

**Funding Source(s)** • Private foundations.

**Primary Purpose** • To apply the national strategy of the Carter Center's Interfaith Health Program at the local level by building congregations and training congregational health promoters (CHPs).

**Materials Used** • Training manual.

**Health Topic(s) Addressed** • Any topic chosen by a participating congregation.

**Geographic Area/Unit** • Urban.

**Program Setting** • Religious institution.

**Target Population** • Residents of Atlanta, Georgia.

**CHA Title** • Congregational health promoters.

**CHID Accession Number** • HE97P0737.



## Training Programs

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274

**Program** • Community Health Advocates.

**Contact** • Chavis, Martha.

**Agency** • Camden Area Health Education Center, 514 Cooper Street, Camden, NJ 08102. (609) 963-2432.

**Program Dates** • Spring 1997–continuing.

**Primary Purpose** • To train local residents as community health advocates.

**Services Offered** • Training, mentoring, and community work experience, including one-on-one health counseling, as well as opportunities for career exploration in health fields. Some graduates are hired by the Camden Area Health Education Center following their training.

**Health Topic(s) Addressed** • One-on-one health counseling on fitness and healthy eating habits, HIV/AIDS, and other sexually transmitted diseases and prenatal care.

**CHA Title** • Community health advocates.

**Program Setting** • Community-based agency.

**CHID Accession Number** • HE97P0680.

275

**Program** • **Community Health Program.**

**Contact** • Ramos, Lori.

**Agency** • Centro San Bonifacio, 1332 North Greenview, Chicago, IL 60622.  
(773) 252-9098.

**Program Dates** • July 1991–continuing.

**Delivery Sites** • Schools, religious organizations, homes, community centers, public health clinics, hospitals/private clinics.

**Funding Source(s)** • Local government agency, grants, community support.

**Primary Purpose** • To help health promoters conceptualize, plan, and implement their own projects with technical assistance from professionals in the community.

**Materials Used** • Various Spanish-language teaching aids on health topics, health promoter training curriculum.

**Health Topic(s) Addressed** • Child health, family planning, HIV/AIDS, mental health, pregnancy/prenatal care, violence, cholesterol screening/education, heart disease, immunizations, nutrition, physical activity, substance abuse, injuries, adolescent sexual behavior.

**Geographic Area/Unit** • Two urban neighborhoods.

**Program Setting** • Community-based agency.

**Target Population** • Adolescents and adults.

**CHA Title** • Health promoter.

**CHA Roles** • Health promotion/education, social support/counseling, project coordination, risk identification, community organizing, patient treatment/services, staff/volunteer supervision.

**CHA Training** • Initial training depends on the project and the CHA's experience; 2–4 hours per month of inservice training.

**CHA Compensation** • \$6.25 per hour plus health insurance, sick/vacation days, educational leave, commuter subsidy, stipends.

## Training Programs

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*Number of CHA's* • 10 staff, 30 volunteers.

*Evaluation Plan* • Yes.

*Methods Used to Recruit CHA's* • Advertising, word-of-mouth referral, referrals from community groups and professionals.

*Methods Used to Retain CHA's* • Graduation ceremony, program certificate, pay increase, career advancement.

*CHID Accession Number* • HE97P0738.

276

**Program** • Community Health Training and Development Center.

**Contact** • Legion, Vicki; Tsai, Cindy.

**Agency** • Jointly sponsored by the City College of San Francisco, Health Science Department, and San Francisco State University, Department of Health Education; Community Health Training and Development Center, 1600 Holloway Avenue, San Francisco, CA 94132-4161. (415) 338-3034.

**Program Dates** • August 1993–continuing.

**Funding Source(s)** • U.S. Department of Education, Carl D. Perkins Vocational and Applied Technology Education Act of 1990, Bernard Osher Foundation, Centers for Disease Control and Prevention, California Office of Statewide Health Planning and Development.

**Primary Purpose** • To improve the primary health care provided to underserved communities by increasing the number of community health workers (CHW's) equipped to provide culturally and linguistically sensitive services.

**Services Offered** • 17-unit evening community college program that issues credits and awards a college credit certificate to graduates; consulting with institutions that wish to replicate or adapt the program.

**Methods Employed** • Competency-based education based on core competencies identified by veteran CHW's and employers. Practical exams guarantee that students have mastered skills at a level required for employment. Scholarships and stipends available.

**Materials Used** • Program implementation manual, objective structured practical exam to measure student proficiency, detailed job task analysis conducted by veteran CHW's, labor market analyses of California and the Bay Area, standards of practice manual, competency-based curriculum.

**Health Topic(s) Addressed** • Family planning, pediatric asthma, chronic disease, HIV/AIDS, pregnancy and prenatal care, sexual behavior, substance abuse, senior health, mental health, child health.

**Program Setting** • Schools.

**CHID Accession Number** • HE94P1515.



## Training Programs

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277

**Program** • **Community Representatives: New Directions in Education Outreach.**

**Contact** • St. Cook, Carol.

**Agency** • County of San Diego, Health and Human Services Agency, Office of Public Information and Health Promotion, P.O. Box 85222, P511E, San Diego, CA 92186-5222. (619) 515-6505.

**Program Dates** • 1992–continuing.

**Delivery Sites** • Schools, worksites, religious organizations, homes, community centers, migrant centers/camps, public health clinics.

**Funding Source(s)** • Federal agency, state government agency.

**Primary Purpose** • To train community representatives as well as providers who may use community representatives in their community outreach efforts.

**Materials Used** • Training guide: *Community Representatives: New Directions in Education and Outreach.*

**Health Topic(s) Addressed** • Child health, pregnancy/prenatal care, immunizations, occupant protection, pedestrian safety, schools and businesses, strategies for large apartment complexes.

**Geographic Area/Unit** • County.

**Program Setting** • Community-based agency, local health and human service organization.

**Target Population** • Coordinators of health-related or social programs and persons seeking to work as individual contractors to such programs.

**CHA Title** • Community representative.

**CHA Roles** • Health promotion/education, outreach, public information.

**CHA Training** • 9–24 hours of initial training and less than 2 hours per month of inservice training.

**CHA Compensation** • \$10.00 per hour.

*Number of CHA's* • 12.

*Evaluation Plan* • Yes.

*Methods Used to Recruit CHA's* • Advertising, referrals from other CHA's, word-of-mouth referral, networking with other CHA programs, referrals from community groups and professionals, university student interns.

*Methods Used to Retain CHA's* • Program certificate, career advancement.

*CHID Accession Number* • HE97P0743.

278

**Program** • Delta Hills Public Health District CHAN Programs.

**Contact** • Carthen, Diane; Tanner, Willie; Dillion, Patricia; Lester, Carrie.

**Agency** • Delta Hills Public Health District, 2600 Browing Road, Greenwood, MS 38930. (601) 455-9429.

**Program Dates** • Continuing.

**Funding Source(s)** • State government agency.

**Primary Purpose** • To improve the health and nutrition of Mississippians by training lay helpers to identify and analyze needs and develop solutions.

**Services Offered** • 10-week health and nutrition training.

**Materials Used** • Video.

**Health Topic(s) Addressed** • Child health, family planning, HIV/AIDS, mental health, pregnancy/prenatal care, stroke, violence, arthritis, cholesterol screening/education, heart disease, immunizations, nutrition, physical activity, substance abuse, cancer, diabetes, high blood pressure, injuries, osteoporosis, adolescent sexual behavior, tobacco use, child abuse/neglect.

**Geographic Area/Unit** • State.

**Program Setting** • Community-based agency, state health department.

**Target Population** • Residents of Mississippi.

**CHID Accession Number** • HE97P1001.

279

**Program** • **Extensions: New Jersey's Voluntary Association for Outreach Workers.**

**Contact** • Katz, Stephanie.

**Agency** • Extensions: New Jersey's Voluntary Association for Outreach Workers, c/o Gateway Maternal/Child Health Consortium, 201 Lyons Avenue, G-3, Newark, NJ 07112. (201) 926-7353.

**Program Dates** • July 1996–continuing.

**Funding Source(s)** • Fees from individual and institutional members.

**Primary Purpose** • To connect outreach workers throughout New Jersey and provide opportunities for the exchange of information.

**Services Offered** • Biannual newsletter; networking and fellowship opportunities; access to regional, statewide, and national information; opportunities to share current practice issues; on-site technical assistance.

**CHID Accession Number** • HE97P0618.



## Training Programs

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280

**Program** • **Health Empowerment Advocacy Program.**

**Contact** • Jones, Rhondette L.

**Agency** • Southeast Raleigh Center for Community Health and Development,  
P.O. Box 28716, Raleigh, NC 27611. (919) 856-6574.

**Program Dates** • March 1994—continuing.

**Funding Source(s)** • Local government agency, private foundation.

**Primary Purpose** • To promote advocacy and empowerment among the underserved, largely black populations in southeast Raleigh and Wake County, North Carolina, by helping CHA's develop their skills in identifying community problems and creating action plans.

**Services Offered** • 10-hour training that emphasizes developing a community vision, identifying community problems, and creating action plans.

**Methods Employed** • Role plays, skits, small/large group discussions, videos, writing exercises.

**Materials Used** • Community Voices, a comprehensive, self-contained leadership development and community action program that emphasizes teamwork, consensus building, and building leadership networks in communities.

**Health Topic(s) Addressed** • Heart disease, nutrition, substance abuse, breast cancer, community leadership development.

**Geographic Area/Unit** • City and vicinity.

**Program Setting** • Community-based agency.

**Target Population** • Black adults.

**CHA Title** • Community health advocates.

**Evaluation Plan** • Yes.

**CHID Accession Number** • HE97P0673.

281

**Program** • MotherNet America.

**Contact** • Linton, Kim.

**Agency** • INMED (International Services for Medicine), 45449 Severn Way, Suite 161, Sterling, VA 20166. (703) 444-4477; 1-800-521-1175.

**Program Dates** • January 1994—continuing.

**Funding Source(s)** • Private foundations.

**Primary Purpose** • To provide technical assistance and information to home visiting programs focusing on perinatal health and broader women's health issues.

**Services Offered** • Technical assistance, training, information, educational materials.

**Materials Used** • *Resource Mothers Curriculum Sourcebook, Women's Wellness Sourcebook, Resource Mothers Handbook, Resource Mothers Implementation Guide.*

**Health Topic(s) Addressed** • Family planning, mental health, pregnancy/prenatal care, stroke, cholesterol screening/education, heart disease, immunizations, nutrition, physical activity, substance abuse, breast/cervical/lung cancer, diabetes, high blood pressure, osteoporosis, tobacco use, domestic violence.

**Geographic Area/Unit** • National.

**Program Setting** • Nonprofit organization.

**CHID Accession Number** • HE97P0681.

## Training Programs

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282

**Program** • New Mexico Community Health Workers Association.

**Contact** • Cielsielski, B.J.

**Agency** • New Mexico Prenatal Care Network, University of New Mexico, Health Sciences and Services Building, Room 123, Albuquerque, NM 87131-5291. (505) 272-9539.

**Program Dates** • Continuing.

**Funding Source(s)** • Robert Wood Johnson Foundation, Henry J. Kaiser Family Foundation.

**Primary Purpose** • To provide networking and training opportunities for community health workers.

**Services Offered** • Quarterly meetings, annual conference, quarterly newsletter.

**Materials Used** • Reaching Out, a training manual for community health workers.

**Health Topic(s) Addressed** • Community outreach addressing health risk factors.

**Geographic Area/Unit** • State.

**Program Setting** • University.

**CHID Accession Number** • HE97P0741.

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## CHID PROGRAM DATA SHEET: Community Health Advisor (CHA)/Worker (CHW)

The Health Promotion and Education subfile of the Combined Health Information Database (CHID) promotes networking and enhances sharing of health promotion information with other health professionals.

If you would like to share your CHA/CHW program information and resources PLEASE

1. Complete this form.
2. Attach your program description, your evaluation plan or forms, and your program materials.
3. Use the mailing label provided to return the form and program materials as soon as possible. (These materials will be cataloged at CDC; they will not be distributed. Anyone requesting the materials will be referred to your contact person.)

Date:

---

### IDENTIFYING INFORMATION

1. Program Name:


2. Agency Name:


3. Program Mailing Address:


4. Contact Person - Title/Position:


5. Internet Address:


6. Telephone Number:

(		)								
---	--	---	--	--	--	--	--	--	--	--

Fax Number:

(		)								
---	--	---	--	--	--	--	--	--	--	--

7. Program Start Date:

--	--	--	--	--	--	--

Program End Date

--	--	--	--	--	--	--

(if known):

---

8. What type of organizations deliver(s) your program? (Check ALL that apply.)

☐

Community-based agency

☐

State health department

☐

Local health department

☐

Religious institution

☐

Other (please specify) \_\_\_\_\_

☐

IHS/Tribal organization

☐

Hospital or medical clinic

☐

School/school system (K-12)

☐

University/medical school



9. What are your program funding sources? (Check ALL that apply.)

☐ Federal agency

☐ State government agency

☐ Local government agency

☐ Other (please specify) \_\_\_\_\_

☐ Private foundation: \_\_\_\_\_

10. Which of the following health problems and issues does your program address? (Check ALL that apply.)

☐ Alzheimer's disease

☐ Child health

☐ Family planning

☐ HIV/AIDS

☐ Mental Health

☐ Pregnancy/Prenatal care

☐ Stroke

☐ Violence

☐ Arthritis

☐ Cholesterol screening/education

☐ Heart disease

☐ Immunizations

☐ Nutrition

☐ Physical activity

☐ Substance abuse

☐ Other (please specify) \_\_\_\_\_

☐ Cancer (please specify type) \_\_\_\_\_

☐ Diabetes

☐ High blood pressure

☐ Injuries

☐ Osteoporosis

☐ Sexual behavior

☐ Tobacco Control

11. Which best represents the geographic area your program serves? (Choose one from a and one from b.)

A. \_\_\_\_\_

B. \_\_\_\_\_

☐ Rural

☐ Urban

☐ Both

☐ One neighborhood

☐ Town/city and vicinity

☐ County

☐ Multicounty

☐ State

☐ Other (please specify) \_\_\_\_\_

12. Where do the CHAs work? (Check ALL that apply.)

☐ Schools

☐ Worksites

☐ Religious organizations

☐ Health maintenance organizations

☐ Homes

☐ Community centers

☐ Migrant center or camps

☐ Public health clinics

☐ Hospitals/private clinics

☐ Other (please specify) \_\_\_\_\_

**13. Which specific target population(s) are served? (Check ALL that apply.)**

*Race/ethnicity*

- ☐ Asian American
- ☐ Chinese
- ☐ Japanese
- ☐ Filipino
- ☐ Other (please specify) \_\_\_\_\_

☐ Pacific Islander

☐ Alaskan Native (specify tribe) \_\_\_\_\_

☐ American Indian (specify tribe) \_\_\_\_\_

☐ Hispanic American

☐ Cuban

☐ Mexican

☐ Central American

☐ Puerto Rican

☐ South American

*Sex*

☐ Male

☐ Female

*Race*

☐ Black

☐ White

☐ Other (please specify) \_\_\_\_\_

*Age*

☐ Children (0-5 years old)

☐ Children (6-12 years old)

☐ Adolescents (13-19 years old)

☐ Adults (20-64)

☐ Adults (65+ years old)

**PROGRAM PROFILE**

**14. How many CHAs are in your program?**

**15. What title do your peer workers use?**

- ☐ CHA ☐ CHW ☐ Outreach Worker ☐ Other (please specify) \_\_\_\_\_

**16. Approximately what percentage of your CHAs are members of the target population?**

- ☐ 0% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

**17. On average, how many hours does a CHA work each month?**

**18. How are CHAs compensated?**

a. Hourly wage

b. Volunteers expenses reimbursed?

☐ Yes ☐ No

☐ Yes ☐ No

If Yes, average hourly rate :\$ \_\_\_\_\_ per hour

c. Other compensation (Check ALL that apply.)

- ☐ Health insurance
- ☐ Child care
- ☐ Sick/vacation days
- ☐ Educational leave
- ☐ Tuition assistance

- ☐ Commuter subsidy
- ☐ Pension plan
- ☐ Retirement account (e.g. 401K)
- ☐ Other (please specify) \_\_\_\_\_

19. On average, how many additional training hours does each CHA receive after being hired?

- ☐ 8 hours or less    ☐ 9-24 hours    ☐ 25-40 hours    ☐ > 40 hours

20. On average, how many additional training hours does each CHA receive after beginning work?

- ☐ < 2 hours    ☐ 2-4 hours    ☐ > 4 hours

21. Who is primarily responsible to train CHAs in your program?

- ☐ Health Educator    ☐ Nurse or other health care provider    ☐ CHA supervisor    ☐ Other CHAs  
☐ Other (please specify) \_\_\_\_\_

22. Does your program have an evaluation plan for use in assessing the program's progress and success in meeting it's objectives plan? (CHECK ONE).

If yes, please attach a copy of your plan and data collection forms.

- ☐ Yes    ☐ No

23. How does your program recruit CHAs ? (Check ALL that apply.)

- ☐ Advertising (bulletins, radio, TV, presentations)    ☐ Word-of-mouth Referral    ☐ Referral from community groups and professionals  
☐ Referrals from other CHAs    ☐ Networking with other CHA programs    ☐ Other (please specify) \_\_\_\_\_

24. What services do your CHAs provide community members/clients? (Check ALL that apply.)

- ☐ Health promotion/ health education    ☐ Risk identification    ☐ Case management (e.g. follow-up after referral or abnormal medical results)    ☐ Treatment or services (e.g. blood pressure reading, nail care for diabetes)  
☐ Social support counseling    ☐ Transportation    ☐ Community advocacy    ☐ Translation  
☐ Medical access counseling (e.g. medical HMOs, child health insurance program)    ☐ Other (please specify) \_\_\_\_\_

25. What recognition do CHAs receive? (Check ALL that apply.)

- ☐ Graduation ceremony    ☐ Certificate(s) from program    ☐ Career advancement    ☐ Academic credit  
☐ Pay increase    ☐ Other (please specify) \_\_\_\_\_



## PROGRAM RESOURCES

**26. Please list the materials that are used in your peer health program efforts.**

[illegible]

27. Primary purpose of the program (include objectives): \_\_\_\_\_

---

28. Is there anything else about your program that you would like us to know? \_\_\_\_\_

---



**PLEASE ATTACH TO THIS SURVEY:**

- 1. YOUR PROGRAM DESCRIPTION**
- 2. YOUR EVALUATION PLAN AND/OR FORMS**
- 3. YOUR PROGRAM MATERIALS (ONE COPY)**

**PLEASE RETURN THESE ITEMS TO:**

J. Nell Brownstein, Ph.D.  
Public Health Educator  
Division of Adult and Community Health  
National Center for Chronic Disease Prevention and Health Promotion  
4770 Buford Hwy. N.E., Mailstop K 45  
Atlanta, Ga. 30341-3724.

**THANK YOU**



